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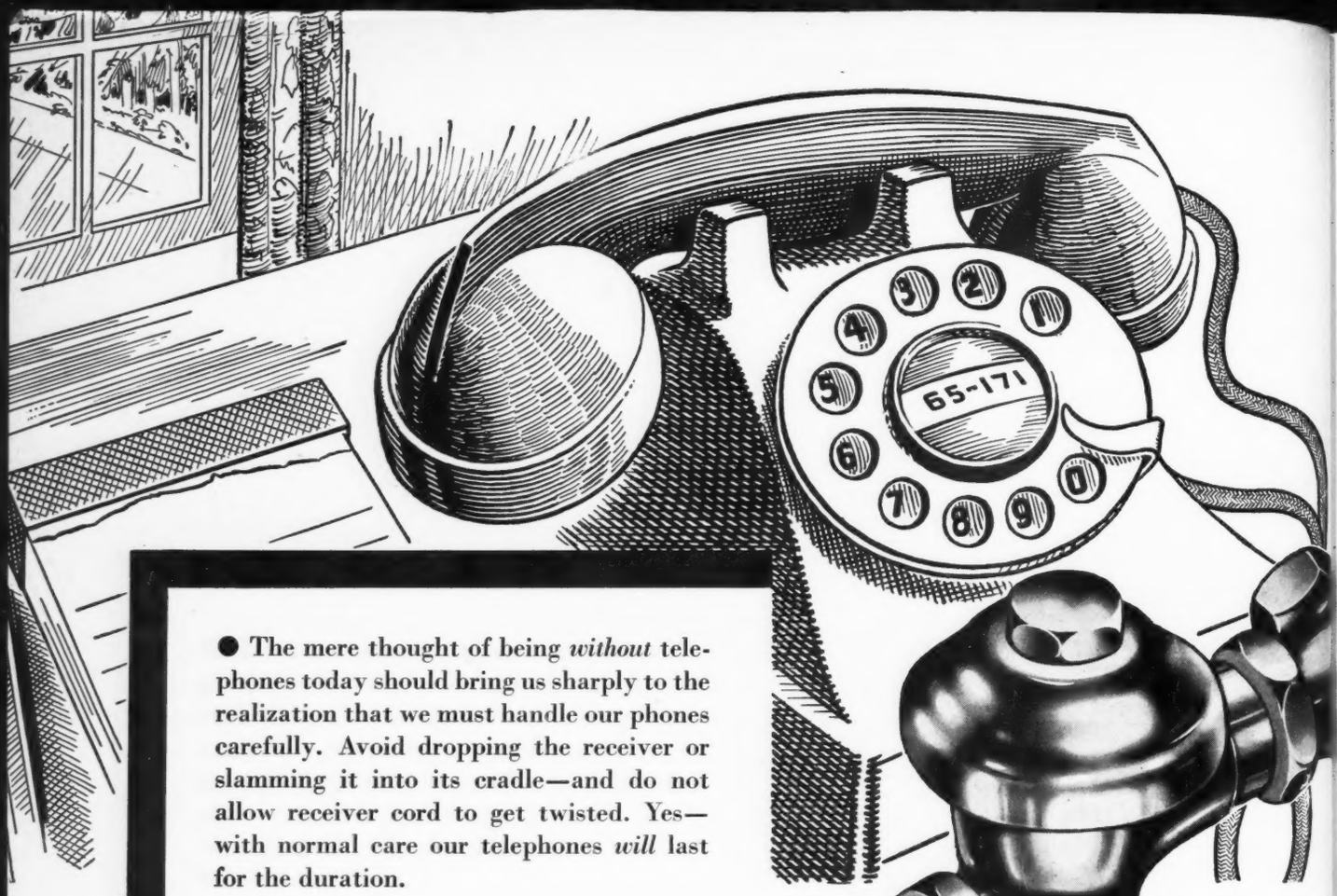
the MODERN HOSPITAL

VOLUME 60 JANUARY 1943 NUMBER 1



● The mere thought of being *without* telephones today should bring us sharply to the realization that we must handle our phones carefully. Avoid dropping the receiver or slamming it into its cradle—and do not allow receiver cord to get twisted. Yes—with normal care our telephones *will* last for the duration.

They rarely need attention BUT . . . they deserve it now

● The same applies to your Sloan Flush Valves. Just because they have served you so well through the years, don't take them for granted. Call in a master plumber today and have him check every one of your Sloan Flush Valves. Probably many of them will need no attention whatever. Probably only a few repairs will be required. But remember, a single part for replacement is a lot easier to get than an entire new Flush Valve. You need to have the assurance that all of your Sloan Flush Valves are working perfectly, still as good as new and ready for many more years of trouble-free service.

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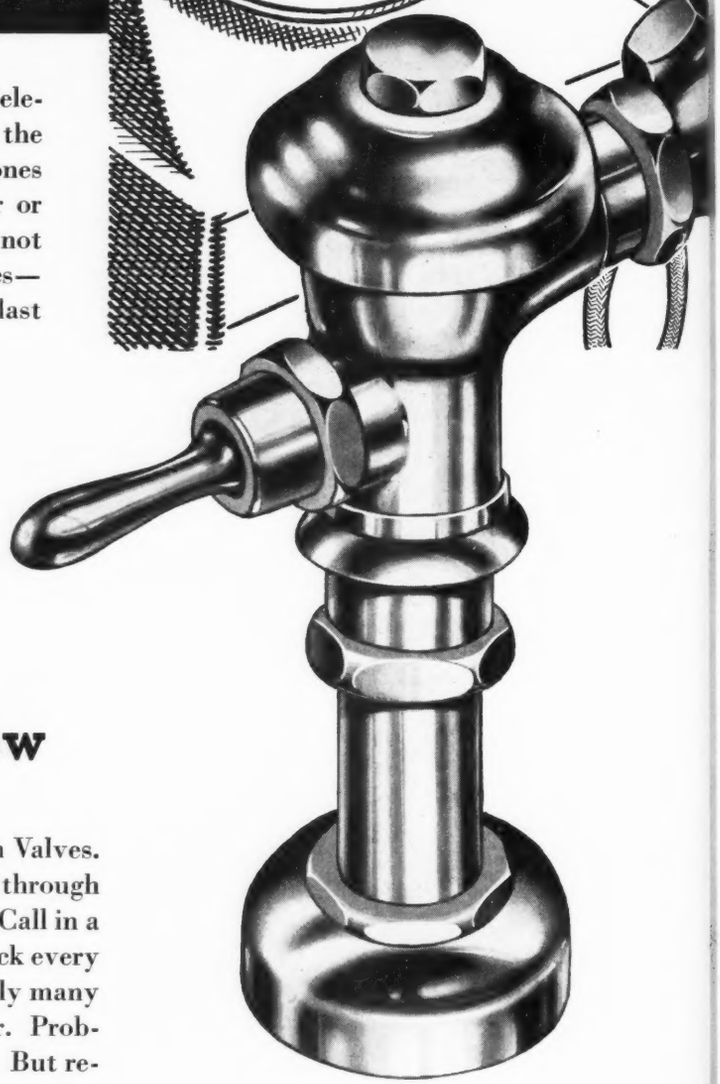

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HEADLINES

ASSOCIATION

Bert Caldwell has decided to be a full-time farmer in Shirland, Ill., thus presenting the A.H.A. with a manpower problem. The association is seeking a new executive secretary, a new editor of *Hospitals* and a Washington representative. p. 124

Do you have an A.H.A. questionnaire on your future equipment needs kicking around in a bottom drawer? Better shoot it in today because the W.P.B. controlled materials plan is to be set up on the basis of consumers' needs. p. 114

BLUE CROSS

Doctor Bishop, acting for the A.H.A., is getting "tough." Blue Cross plans that don't live up fully to their responsibilities will find it hard to get approval. A 15,000,000 total enrollment is the 1943 goal set for the plans. pp. 45, 128

But will hospitals support these moves fully? The administrators' section of the Chicago Hospital Council threw cold water on a proposed ward service plan.

Louis H. Pink is Doctor Goldwater's successor not only as president of Associated Hospital Service but also as Hospital Service Plan commissioner. p. 128

OIL

Will you help save 10,000,000 gallons of fuel oil this winter? p. 69

FOOD

"Don't discriminate against us" is the hospitals' cry on food rationing. Governmental hospitals can get their meat outside the quota but not so the voluntary hospitals. p. 118

Meanwhile, Everett Jones will do his darndest to see that hospitals get a fair share of canned fruits, juices and vegetables. p. 102

Butter, ice cream and such, now limited under a temporary order, will soon be rationed, but Jones tells how to get powdered milk. p. 102

MATERIEL

Better get acquainted with your regional representative of the Governmental Division of W.P.B. Don't buy a motor for your sewing machine big enough to run a street car. p. 102

When after weeks of delay you finally get an A-1-j rating for a new sterilizer and telegraph the good news to the manufacturer, don't expect the sterilizer on the next train. Your rating merely lets the factory start work. p. 116

DEATHS

Dr. Warren L. Babcock, retired administrator of Grace Hospital, Detroit, died suddenly on December 27.

CONSTRUCTION

Give them the facts, if you want to build. "Them" is the W.P.B. and "the facts" are the answers to 15 questions. The situation regarding floor coverings, roofing and siding has been clarified by amendments. p. 104

If you can't get roofing, try gypsum says W.P.B. p. 114

PERSONNEL

"Sure, hospital employment is 'essential' but the wage and salary freeze still applies." That is the present situation as outlined by W.M.C. and W.L.B. Hospitals, like other employers, must fill out manning tables and withdrawal and replacement schedules. They'll be a headache, of course, but are designed to make withdrawal to the armed forces more orderly. p. 108

EDUCATION

The Minnesota hospital institute, January 11 to 16, will stress war problems, plant operation difficulties and postwar hospital planning. p. 130

NURSES

"Accelerate, accelerate" on nursing education is the latest request of the subcommittees on nursing and hospitals. p. 112

The idea of paying students bobs up again, this time with appropriate blessings of these two subcommittees. Doctor Parran asks for more money for nursing schools. p. 112

The Red Cross is out to recruit 30,000 nurses for 1943 (page 118). The Army has a special school for air force nurses. p. 120

FIRE

The Cocoanut Grove fire gave Boston lessons on preparedness. p. 56

TAXES

When Uncle Sam's taxes take so much, it becomes much easier to give to hospitals (page 47). But the Victory Tax means more work for your bookkeeper, even with the simplified table. p. 57

California hospitals, carrying the ball for all of us, won a resounding court decision defining a charitable hospital. p. 126

INTERNS

For the benefit of our injured soldiers in Guadalcanal or Tunisia, we must again comb the list of interns, residents and fellows. The Army-Navy college training program puts Uncle Sam in the education business in a big way. p. 106

For full news coverage of the month, see news section beginning on page 102.

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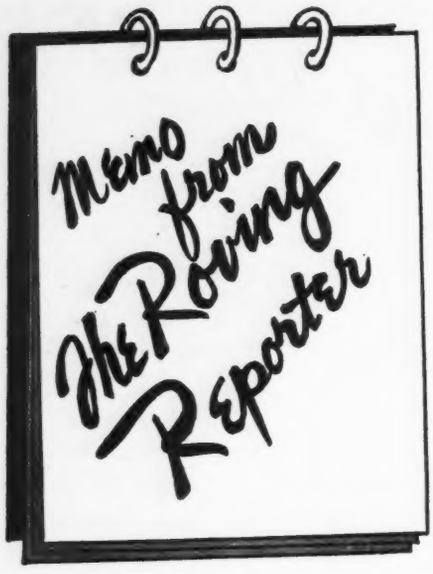


"U. S. A. Shall Win"

What sort of neighbors do we have to the South of us? "Since long ago," to quote one of their phrases, we have had polite neighbors, for the Latin Americans are unfailingly polite. But now we have friendly neighbors as witness the rubber stamped message in red ink that adorned a recent letter from Compañia Medica Peruana of Lima, Peru, which reached The MODERN HOSPITAL recently as a part of the extensive inter-American correspondence that has grown up since the publication of *El Libro del Hospital Moderno.*

The message stamped on the letterhead just above the date line is as follows:

> WE WORK FOR THE U. S. A. VICTORY; WE ARE FULLY CONFIDENT IN THE U. S. A. SUCCESS FOR THE FUTURE WELFARE OF MANKIND. U. S. A. SHALL WIN. GOD HAS ORDAINED IT SO.

Does that not warm your heart?

• •

Protects Patients and Interns

Like most nonteaching hospitals, Samaritan of Troy, N. Y., lacks interns. Its regular quota is eight and it now has two. The medical staff, after months of consideration and trial, recently voted to preserve its program of intern education and worked out a scheme whereby the two interns would not be giving frenzied, superficial consideration to the 200 patients but could be assured the necessary time to study and care for a much smaller number of patients for whom they would then be held responsible.

Mrs. Helen L. Warren, the superintendent, describes the plan as follows:

"Obviously, such a program can be done only at the expense of time and sacrifice on the part of the attending staff. One intern has been assigned to ward cases in the medical department and the other to the surgical department. The attending physicians of other departments have assumed full responsibility for detailed care of their patients, including private patients. This means that even senior attendings are on call for intravenous injections, catheterization and transfusions.

"This noteworthy solution of a vexing problem has been made possible by unselfish physicians who have not only their patients but the ideal of education truly at heart."

• •

Telephone Numbers

A number of our larger hospitals issue their own telephone directories but none does a smarter job of it than Massachusetts General.

The new edition has a varnished blue cover, a title page bearing a pen and ink sketch of the main building and a thumb index. Clever use is made of areas that less skilled planners might have left blank. For example, the inside front cover contains data on visiting hours and regulations and dining room service. The inside back cover, in combination with the final page, is a plot plan of the buildings. On the outside back cover is a summary of the more significant air raid instructions from the hospital's manual, "Air Raid Precautions and Casualty Preparation." In the center of the directory appears an aerial view of the institution.

A smaller institution might imitate the directory of this famous Boston hospital by a mimeographing or multigraphing job.

• •

Something New in Reports

A new note in annual reports is struck by the Municipal Hospitals of the City of Winnipeg, Canada, in the inclusion of a popular article entitled "Surgeon's Progress," picked up with permission from *Hygeia* and the *Reader's Digest.*

The article fits in so well with the hospital's educational program that it is well worth the four pages assigned to it. Winnipeg's is a mimeographed report with a heavy paper cover and spiral binding. The magazines quoted are not largely circulated in Canada and the article is an interesting change of pace from the reports of departments and statistical data presented earlier in the book.

Not the particular article but the idea of injecting into the annual report something pertinent by a popular author might be worth imitating. Dr. Dougald McIntyre is medical superintendent of the Winnipeg city hospitals.

To Relieve Tension

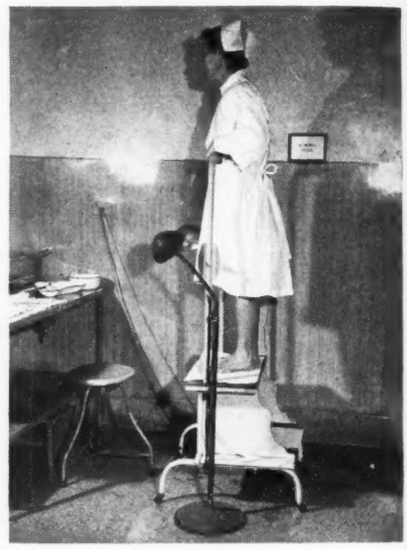
Here is sure relief for those tense moments when department heads gather for one of their meetings during these difficult times. Flower Hospital, Toledo, Ohio, vouches for the effectiveness of the treatment.

Before the meeting gets down to actual business each one must tell a joke. It doesn't have to be new; it doesn't have to be a side-splitter. Some little anecdote is sufficient. But woe betide anyone who comes unprepared! When facial muscles are seen to relax and smiles replace wrinkles and frowns, attention is directed upon the problems of the day.

• •

Platform for Patients

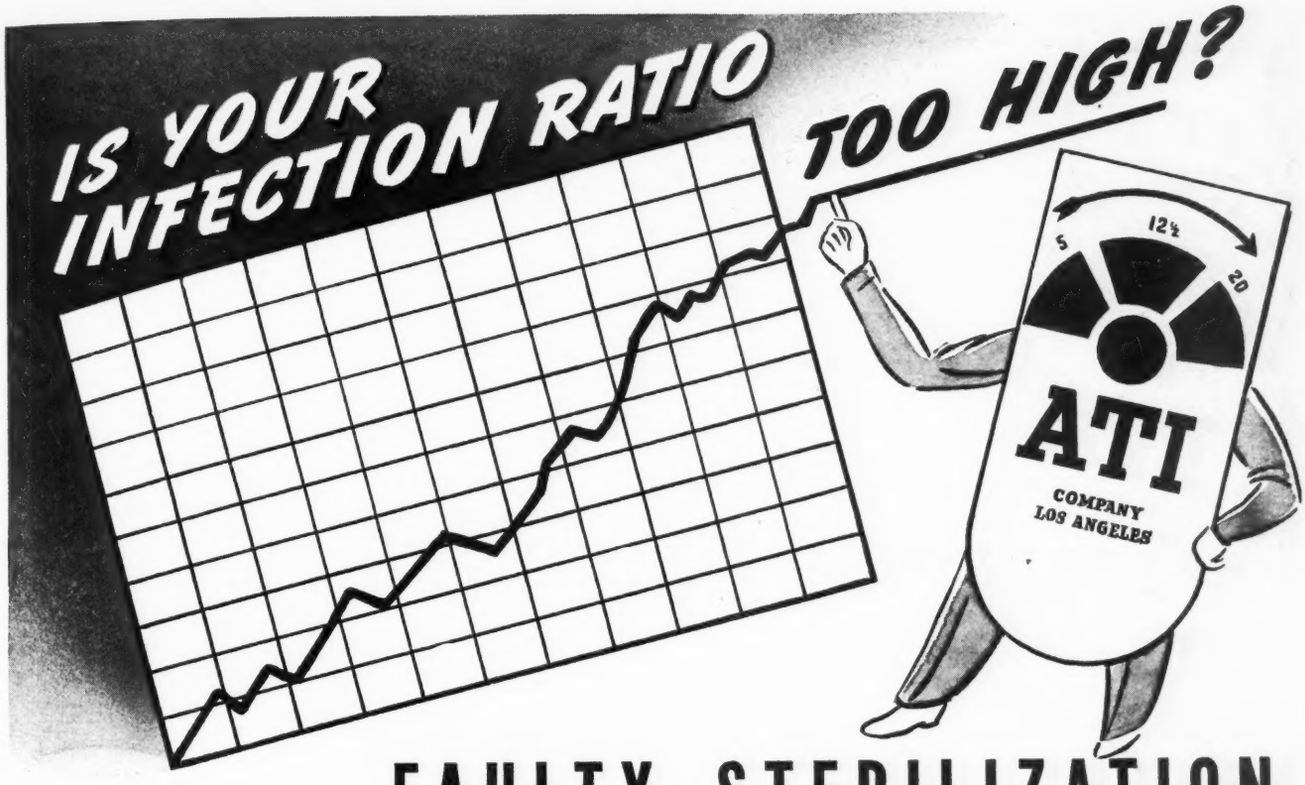
In Beth Moses Hospital, Brooklyn, N. Y., the patient receiving treatment for varicose veins stands up and takes it in comparative comfort thanks to the inventive mind of Fanny Schlein, director of the out-patient department. Mrs. Schlein noted every now and then that some patient who was being treated while standing on an examining table would



suffer from dizziness and general insecurity. So she conceived the idea of the platform illustrated here.

She describes it briefly as follows: "A discarded metal bed raiser and some lumber, found in the carpenter's shop, with four casters which are fastened to the tubular legs of the stand are all there is to it. The result is that the physician and the patient both have greater comfort since the doctor is seated while administering treatment and the patient feels secure in gripping the frame.

"The platform also has the advantage of being small in size and easily stored in a limited space. Taking into consideration our national watchword of 'priority,' we have found this device extremely helpful."



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READER OPINION

Request for Construction Costs

Sirs:

Our interest in your monthly magazine is limited to the sections devoted to text and illustrations relating to hospital building construction. We find this material informative and of value and trust further issues will continue similar material.

I would appreciate your consideration of our suggestion for the inclusion of one rather simple addition under "Construction Details." Cost data on new building construction should, in our opinion, be identified with a date to be of maximum value. This date, if possible, should be the month and the year of signing a contract rather than the completion date of a hospital.

We would appreciate receipt of this dated information on new hospital construction that has been shown in your magazine during the last year or two.

Roger C. Kirchhoff
State Architect
State Bureau of Engineering
Madison, Wis.

Questions Survey Interpretation

Sirs:

Many thanks for your kindness in making available to me several copies of the issues of The Modern Hospital which contained the two reports on the canvass of opinion which you and Dean Conley made among A.C.H.A. members.

I am not in a position fully to evaluate your study, in view of the fact that in submitting the Social Security Board's proposals you, apparently, did not submit anything actually proposed by or prepared by the Social Security Board but, instead, used material which you say was prepared by the director of the Commission on Hospital Service. The material in question is not included in your articles and the reader can only guess as to its precise contents.

I should be interested in seeing the material that was actually made available for those to whom your questionnaire was sent and which, presumably, is the basis of the understanding which the study intended to give the A.C.H.A. members of the proposals on which they were voting when replying to specific questions. From the content of your first article, I assume that question 3 in the October issue is so worded as to identify with the Social Security Board's proposals the issue which is explicitly covered by this question.

In light of these comments, there is one point in your analysis to which I take definite exception. It is interesting to have the results of your detailed analysis based upon notes, comments and relationships internal to the questionnaire replies. Material of this kind is always illuminating. However, it seems to me that the analysts go quite beyond their province when they undertake to use such notes to reverse the replies which the respondents gave.

It is my understanding of the rules of the questionnaire technic that you are bound by the questions posed and by the answers received. If experience shows that there are ambiguities in the questions or misunderstandings among respondents as to what the questions mean, evidence on these points is properly pointed out in the analysis of the results. The reader then has the privilege of judging for himself what significance attaches to the replies obtained.

Your study says that on question 3 you obtained 165 "Yes" and 131 "No" responses. It seems to me that it goes beyond the privileges of the analyst for you to say (under a heading, "Majority Is Opposed") that the majority of the hospital adminstrators do not favor the Social Security Board's proposals when, in response to the direct question 3, a clear majority of your respondents said they did favor them.

I should be glad to see the additional material and to have your reactions to my comments.

I. S. Falk
Director
Bureau of Research and Statistics
Federal Security Agency
Social Security Board
Washington, D. C.

Convention Report Approved

Sirs:

My sincere congratulations on the finest convention reporting I have ever seen. Your pen sketches of leading speakers are excellent. Your informal but accurate reporting commands attention and respect.

I sincerely hope that you are planning to prepare a special convention digest and make it available to hospitals in order that it may be distributed to appropriate department heads and interested board members.

I would like to congratulate you and Dean Conley on your follow-up of the Social Security Board's hospitalization proposals. I think that the comments coupled with the statistical data in the October issue are definitely worth while.

Gerhard Hartman
Director
Newton Hospital
Newton Lower Falls, Mass.

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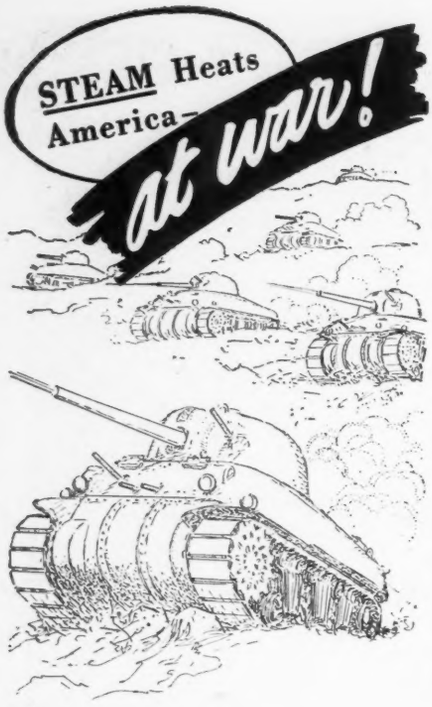

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SMALL HOSPITAL QUESTIONS

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Vacation After Resignation?

Question: How much, if any, vacation is allowed employes who resign before the end of the year's service?—A.B., Mich.

ANSWER: It depends upon the rank the employe holds, of course, but for the average person the feeling seems to be that if he resigns before the end of the year's service he is entitled to no vacation.

This is on the theory that the vacation is a gracious gesture on the part of the employer to help his employe give him another year of efficient service. In hiring him, it is usually only stipulated that the salary shall be a certain amount for the period served, with no mention of a bonus upon termination of the service, which is what a terminal vacation amounts to. So it is usually given only in exceptional cases in which the resignation is caused by some reason meriting special consideration.—NELLIE GORGAS.

Routine Laboratory Procedures

Question: How much of a routine laboratory test program is carried out by small hospitals (150 beds and less)? While a routine program is carried out by all large hospitals, there are some objections to this routine in smaller hospitals, especially when this work is also carried out in the doctor's office. They object to having the work repeated when the patient is hospitalized. It would seem as necessary that the patient's welfare be protected in the small and average sized hospital as in our large medical teaching hospitals. What is the usual charge made for routine laboratory examinations and which tests should be considered in the routine laboratory tests?—M.M., Ill.

ANSWER: Adequate laboratory work is just as necessary to the patient in the small hospital as it is to the patient in the large hospital. The difficulty is that the staff members of the small institutions are generally not as interested in carrying out proper laboratory procedures as are physicians practicing in the large hospitals. Work that has been carried out in the doctor's office by competent technicians within a day or two preceding admission to the hospital should not be repeated if the findings of those tests are reported to the hospital and included in the patient's history.

The usual laboratory procedures for a major operative case would include routine urinalysis, a complete blood count, complete blood chemistry and PSP; if the hemoglobin is below 70 per cent, grouping and matching with possible blood donors.

For surgical cases that are not of an elective character, viz. an acute appendicitis case, white and differential blood counts and urinalysis are sufficient. The average medical patient has laboratory work of a fairly limited nature, depending on the need and on the physician in charge.

Laboratory fees affect the type and number of examinations that may be carried out as routine. There are many variations in laboratory charges and there is much to be said for the system that includes all laboratory work under the daily room and board charge. Another and generally satisfactory way is to charge standard fees for the first $5 worth of work and then to grant a 50 per cent discount on the established charges for all work in excess of the original $5. Either of these systems will make it possible for the doctors to carry out a real laboratory test program without burdening the patient with excessive costs.

An excellent article giving much more information on this subject was written by J. T. Morrison and published in the March and April 1941 issues of The MODERN HOSPITAL.—WILLIAM J. DONNELLY.

When the Baby Dies

Question: On obstetrical cases when the baby is stillborn or dies soon after birth, is a reduction made in the bill for this reason? —D.W.R., Mass.

ANSWER: Most maternity rates, whether they are flat rates or per diem rates, include the care of the new-born. When such a policy exists no reduction can be made when the baby is stillborn or dies soon after birth. By the same token no additional charge can be made for multiple births.

If, however, it is the policy of a hospital to make a separate charge for newborn patients, it cannot make a charge when the baby is stillborn or dies soon after birth. This might be considered a reduction. These hospitals could justly make additional charges for multiple births.—W. H. HUNT.

Keeping X-Ray Plates

Question: Is it necessary to keep negatives or plates if the x-ray report is written up on patient's record?—V.E., B.C.

ANSWER: X-ray films that show positive findings should be kept from three to five years or, at any rate, until the statute of limitations has passed. It is true that the written record is of considerable value, but the film itself is of the greatest value and in case of disputed interpretation would be indispensable. I favor keeping x-ray films for ten years at least. For research and reference purposes the film is much better than the written report. However, many hospitals do not keep the films for more than three or five years but depend on the written report in the patient's file.—M. T. MACEACHERN, M.D.

Nurse's Salary During Illness

Question: When general duty nurses belong to a hospitalization form of insurance, is it customary to pay their salaries when they are hospitalized?—M.B.C., Mass.

ANSWER: YES.—OLIVER H. PRATT.

Some Average Laboratory Fees

Question: Could you send us the average charges for blood chemistries, gastric analysis and basal metabolism, also for gastrointestinal series, gall bladder series and pyelograms (these to be in hospitals of from 65 to 100 beds)? Does the supervision of a pathologist or roentgenologist influence the price of the examination?—E.N.R., Okla.

ANSWER: Average charges for these procedures are as follows:

Blood chemistry, $10.
Gastric analysis, $5.
Basal metabolism, $5.
G. I. series, $25.
Gall bladder (2 exposures), $15.
Pyelograms (3 exposures), $15.

Yes, having this work supervised by a pathologist or roentgenologist does influence the prices.—R. L. LOY JR.

Collecting for Accident Cases

Question: What do you do about collecting bills for accident cases when you, or the patient, think that the insurance company may be responsible for the bill? What do you do when you don't know whom to hold responsible for bill?—M.McC., Tex.

ANSWER: If there is no doubt as to the liability in the case, one is reasonably safe in taking an assignment for the amount of the bill, *i.e.* if you are certain that the insurance company will protect the hospital. The carrier can easily do this by making the check payable to both hospital and claimant. If there is a question as to liability, then the safest procedure is to collect directly from the patient.—A. A. AITA.

LOOKING FORWARD

Design for Rehabilitation

DISEASE and disaster today stalk in the wake of war. In Greece, Albania, the Netherlands, Poland, Norway, France, Russia, China and the many other war torn or enemy occupied countries reports show that health conditions are bad and growing steadily worse. Even in Germany, malnutrition and disease are growing. When peace finally comes and there is a chance to bind up the world's wounds, hospital and medical care for the victims of war must come, even ahead of food and clothing, at the top of the list.

In the postwar period the United States will be engaged in a vast new lend-lease program for humanitarian rather than martial purposes. The seriousness with which our government now faces this responsibility is indicated by the fact that Herbert H. Lehman, former governor of New York, has been drafted to head the program. Apparently for a time we shall feed and clothe those who so urgently need our help. Even more immediately essential, however, will be medical care to stop the ravages of disease.

When peace comes our Army and Navy will doubtless have a huge unused supply of medicines, dressings and other medical, surgical and hospital supplies and equipment. To dump these on the domestic economy at bargain rates will, as the publisher points out in this month's "After Hours," result in serious disturbances. To give them away to the starving, plague-ridden peoples of the world wherever found will cost us but a few cents per capita and will earn for us the gratitude and respect of millions. The repercussions in international politics of such a move may well strengthen America's postwar leadership.

Governor Lehman, perhaps using the facilities of the American and the International Red Cross organizations, can well take this broad humanitarian step.

The 1943 Program

AS A program for 1943 the hospitals of the United States can well put their full enthusiasm behind the six point plan that was ratified by the house of delegates at St. Louis. This plan urges (1) immediate establishment of low-cost contracts by each Blue Cross plan; (2) cooperation in the development of medical service plans for hospital cases; (3) encouragement of local government payments to hospitals for care of the medically needy; (4) encouragement of federal financial assistance to states for care of public assistance beneficiaries (aged, blind, dependent children and those on general relief); (5) federal grants for improving and expanding voluntary hospitals in defense areas and other communities with special need, and (6) deferment of hospitalization under the Social Security program for the present.

The Bishop resolution is, in effect, a vigorous attempt to carry out part of this program. As chairman of the committee on approval of the board of trustees, Doctor Bishop is now in a position to see that the resolution actually becomes a living reality. In this he has the warm support of the leading Blue Cross executives. The standards for approval of Blue Cross plans have been made more specific and are to be enforced more vigorously.

Special efforts are being made to speed up enrollment in existing Blue Cross plans to a total of 15,000,000 persons by the end of 1943, to inaugurate new medical care plans and new Blue Cross plans in those states now without such coverage, to encourage low-cost plans and to consolidate or strengthen plans that are not fully meeting their responsibilities. A recent report on nonprofit medical service plans issued by the Hospital Service Plan Commission gives the important details regarding the 11 medical plans affiliated with existing Blue Cross plans. Only one so far, the Michigan Medical Service with 480,000 subscribers, has a large membership. Perhaps some new approach to the particular problem is indicated.

A uniform national hospital contract for national accounts has been recommended. Intensive study is to be made of enrollment of rural dwellers and of individuals.

These various facts mean that the work of the Bishop committee and of the Hospital Service Plan Commission is effectively dealing with the points on low-cost plans, medical service plans and the extension of the Social Security program. What about the other proposals of the six point program? These are exclusively

the responsibility of the hospitals and an equally intensive program should be undertaken to make them effective.

The joint committee of the American Public Welfare Association and the A.H.A. has, over the years, ironed out most of the thorny problems concerned with local government payment for hospital care of the medically needy. Hospitals should now influence state, county and city governments to put into effect the excellent program that national leaders have visualized. The work of the Minnesota Hospital Association in this respect was described by A. G. Stasel in our December issue.

For federal aid to public assistance beneficiaries Representative Coffee of Washington introduced a bill (H.R. 7411) which would apparently do just what the hospital groups have requested. Strong support should be given to a similar bill which should be introduced in the new Congress.

The fifth point—federal financial aid for hospital construction—has been given some effect through the Lanham Act. But the urgent need of structural materials by war industries has forced the W.P.B. to stop almost all hospital construction for the time being. While the Lanham Act needs improvement in its details, the general program of federal aid in the construction of needed hospitals in areas that cannot finance their own should go forward vigorously as soon as the materials shortage can be licked. This is an important field for postwar public works.

Here is a practical program to provide essential hospital care and assistance in meeting medical costs for all of the American people—indigent, low wage earners, well-to-do, urban and rural. Hospitals and Blue Cross plans alike should give it every support in 1943.

Doctor Caldwell Resigns

AFTER fifteen years as executive secretary of the American Hospital Association, Dr. Bert W. Caldwell has resigned and has been appointed executive secretary emeritus. As he retires from his strenuous duties, the best wishes of the entire hospital field go with him.

Many things have happened since Jan. 1, 1928, when Doctor Caldwell took over the major responsibility for the work of the association. The institutional membership was then about 1200 as contrasted with more than 3000 today. The activities of the association were modest and centered largely around the annual convention, in sharp contrast to the multifarious year round activities now. In 1928, for example, only one technical bulletin was published as contrasted with 19 in 1940 and 10 in 1941. The association's total annual budget, not including the funds of the Hospital Service Plan Commission, has nearly doubled during the period. Institutes for hospital administrators, accountants and purchasing agents have been inaugurated. The indebtedness on the headquarters building has been paid.

One could recount many more changes that have been effected during Doctor Caldwell's tenure of office, but to do so would be distasteful to him for he would be first to share the credit with fellow workers.

His personal qualities especially have endeared him to thousands. His genial humor, his wide acquaintance in the hospital field in all parts of the United States, Canada and Latin America and his natural calm in the face of perplexing problems are among the attributes most often mentioned.

As Doctor Caldwell moves to the northern Illinois farm which he purchased some years ago in anticipation of his retirement, it is unlikely that his vigor and abilities will be entirely lost to the hospital field. His rich experience started with some ten years as superintendent of Santa Tomas Hospital, Panama, followed by work for the Red Cross in the Balkans, war service as a colonel in the Army Surgeon General's office, executive work for the U. S. Public Health Service in the Chicago district, direction of the Rockefeller yellow fever commission in Mexico and administration of the Allegheny General Hospital, University of Iowa Hospitals (which were largely constructed under his direction) and Tampa General Hospital, Tampa, Fla. Association officers and individual hospital administrators will doubtless continue to draw upon him for guidance and counsel for many years.

Forty-Eight Iron Lungs

A RECENT news dispatch tells of another hospital windfall. Under the terms of the will of one Mrs. Blanche Gilbert, a widow, 30 hospitals in the Philadelphia area it seems will receive 48 iron lungs. As sad as it is to contemplate what use some of these hospitals may make of this important but not always essential equipment, sadder even is it to ruminate on the use that an individual can make of her fortune. Despite efforts that have been taken to enumerate specific hospital needs and to divert possible bequests to constructive uses, the waste continues and will persist no doubt as long as there remain sums to be dispensed in such manner.

But what cannot be prevented can sometimes be corrected. There is always the possibility of taking inventory of community health and hospital assets and reallocating nonessentials where they may render the greatest service. Such study and reorganization imply new thinking in terms of group interests on which the more optimistic of us are pinning our hopes for a more abundant future life. What we may expect when we actually get around to taking community inventories is hard to foresee. There is reason to believe, however, that Mrs. Gilbert's 48 iron lungs will fade into insignificance in the light of more important revelations.

Make the Most of Those HIGH TAXES

The ill wind of high income taxes may blow good to hospitals by stimulating the public to make larger gifts—if the hospital's case is legitimate and if it is properly presented

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IT IS the generally accepted observation that high taxes "make it impossible" or "more difficult" for people to give to hospitals. This is not necessarily true. Indeed, under present conditions and those we are likely to experience during the next several years, high income taxes may be made to serve as a stimulus to giving to voluntary hospitals.

This is entirely in harmony with both the letter and the spirit of patriotism because the federal government wisely recognizes that the load assumed by voluntary social agencies relieves the government budget by a similar amount.

Gifts Can Be Deducted

This situation derives from the provision that gifts to hospitals and other nonprofit social agencies can be deducted from net income in making federal income tax returns. This fact has been employed generally for many years as an auxiliary argument for subscribing to hospitals, although often it has not been set forth clearly and forcefully enough to be of any great value. As a matter of fact, the tax benefits on account of gifts in the past have not been so substantial as to rank as a primary consideration.

Today, the tax situation is being employed with powerful effect to the advantage of certain progressive hospitals that have undertaken constructive, urgent programs. To pick only one example, there is the elderly woman who, when she first heard about a certain hospital's program, determined to sacrifice $20,000 of her income in order to help. When it was clearly explained to her how much more she could do by taking advantage of the provisions of the federal income tax law, she made her subscription $117,300. The net cost to her in the end probably will be only a small fraction of the sum she first contemplated.

Under the Revenue Act of 1942 tax benefits apply to a vastly greater number of incomes and are much more worth while. Almost every family is going to pay federal income tax of at least 19 cents on the dollar (after limited exemptions). This means that dollars given to hospitals cost the taxpayer only 81 cents, even in the low income group.

The middle-income class, the group designated by some experienced fund raisers as "relatively ungenerous," has more substantial benefits. Accordingly, the potential stimulus of income tax deductions among the middle-income group is extremely important. This numerically thick stratum of the population has a giving ability greater than the more numerous poor or the considerably fewer rich.

Much has been said about "broadening the base of support" for nonprofit institutions. Except for community chests, little has been done. Heavier income tax rates, enhancing the relative value of deductions, may well make it possible and practical to tap the reservoir of middle-class support.

It should not be imagined, of course, that this reservoir-tapping will be automatic. It will not. The present situation is an opportunity only, not a ready-made miracle. No matter how fair the wind, one must still have the gumption to make sail.

Benefits that are attractive to the small income taxpayer become almost irresistible, if adequately presented, to the taxpayer in the higher brackets of the surtax schedule. However, the more prosperous individual generally has a more complex situation; one can generalize only by considering a hypothetical case.

The new tax law leaves less individual income for personal use than ever before in our history, and that is the realistic, pertinent index of the terminal effect upon the taxpayer—the amount remaining to spend on living or to invest.

No one can actually make money by giving to a hospital, although there are instances in which this does seem to be the case for all practical purposes. However, tax benefits greatly reduce the net cost of the gift. The most realistic consideration is: "How much will I have to live on this year?" The following analysis of the whole problem is confined to that point of view.

Suppose You Have $50,000

The assumptions of this hypothetical case are that an individual after personal exemptions and deductions, and after payment of the 5 per cent Victory tax on earned income, has a net taxable income of $50,000. The Victory tax is not computed in order to simplify calculations, and benefits on account of earned income are not computed for the same reason. No material distortion results from this simplification.

The accompanying table shows savings in individual income taxes (not including the Victory tax) based on the assumption that the gift is made out of income. The schedule shows that if a person has a net taxable income of $50,000 and does not take advantage of the deduction of gifts to hospitals or other charitable organizations, his income tax under the present law will be $26,240, which will leave him $23,760 available for living.

Savings on Federal Income Taxes Allowable Because of Contributions

Net Income After Deducting All Exemptions Except Gifts	*Combined Federal, Normal and Surtaxes*	*Assumed Contributions*	*Income Tax After Gifts*	*Tax Savings Resulting From Gifts*	*Actual Net Cost of Gifts to Subscriber*	*Per Cent of Gifts Absorbed by Government*
$ 2,000	$ 380	$ 300	$ 323	$ 57	$ 243	19
3,000	600	450	501	99	351	22
4,000	820	600	688	132	468	22
5,000	1,080	750	885	195	555	26
8,000	1,940	1,200	1,580	360	840	30
10,000	2,620	1,500	2,110	510	990	34
15,000	4,680	2,250	3,695	985	1,265	43
20,000	7,160	3,000	5,630	1,530	1,470	51
30,000	13,020	4,500	10,290	2,730	1,770	61
50,000	26,240	7,500	21,095	5,145	2,355	69
60,000	33,440	9,000	26,960	6,480	2,520	72
70,000	40,940	10,500	33,080	7,860	2,640	75
100,000	65,140	15,000	52,790	12,350	2,650	82
200,000	151,140	30,000	125,040	26,100	3,900	87
300,000	239,140	45,000	199,540	39,600	5,400	88
500,000	415,140	75,000	349,140	66,000	9,000	88

If the same man makes a gift of $7500 from income (15 per cent of his taxable income), his tax will be reduced to $21,095 and will leave him $21,405 for living. The government has absorbed 69 per cent of the gift through income tax deduction, and he has only $2355 less for living than if he had not made the gift.

However, if he were to make the $7500 gift out of capital, his federal income tax would remain at $21,905, but he would have available for living $28,905. He makes a $7500 deduction on his income tax return, without taking that sum from the amount available for living. In subsequent years, the income from invested capital would be reduced by $300 gross (assumed annual yield at 4 per cent on $7500), which after taxes at present rates would be no more than $93 a year for living.

In this discussion, the federal income tax has been considered exclusively, because of the variations of the regulations applying to the several state income tax laws. Several of these grant tax benefits on account of contributions on the same principle as the federal law. The deductions are not so important, perhaps, as in the federal tax return because the rate of tax is lower, but in the instance of the New York State law, for example, the benefits are quite substantial.

Elderly persons of a realistic turn of mind, who wish to pass on to their heirs the largest possible estate and yet make a gesture of good will in their will, may be influenced by savings in computing the estate taxes to make gifts while they still live. These savings may be enormous and they are, of course, in addition to income tax benefits, federal and state. Demonstrations are complicated, but they always prove out.

The source of the gift, whether from capital or income, makes a considerable difference in the amount of tax paid, hence in the amount available for living. There may be still other advantages in going through with the actual conveyance of securities or other property to the hospital on account of the provisions in the law for capital gains or losses. This can be demonstrated by examples which would consume more space than is available here, but the considerations involved may be quite large and may reduce the final net cost of the contribution to the vanishing point.

Another aspect of the law is the effect if the contribution is made by, or through, a corporation. Most corporations, until a half dozen years ago, gave only nominal financial support to programs for the enlargement of community hospitals.

However, the attitude of organized business has undergone change. On the basis of enlightened self-interest, industry, commerce and finance have often assumed a major share of the cost of the improvement and enlargement of the community hospital plant.

The federal government approves such philanthropy by making these gifts specifically deductible from net income. Deductions on account of charitable contributions of 5 per cent of net income before taxes in a single year are permitted. The government thus gives evidence of its endorsement of such contributions by absorbing up to 90 per cent of their cost (not correcting for 9 per cent postwar credit on excess profits tax but allowing for the $6000 deduction, which is excluded from excess profits tax).

The most striking opportunities, perhaps, occur in a corporation that is closely held and that can be used as the instrument of its stockholders. Here is how it works:

Assume that the taxpayer is one of three equal shareholders in a corporation having $450,000 subject to excess profits tax. Each shareholder agrees to a corporate gift amounting to 5 per cent of profits, *i.e.* $22,500 ($7500 each), thereby reducing the dividends he would otherwise receive, after excess profits tax, by $917. Inasmuch as this amount would be subject to personal income tax at the rate of 72 per cent, should he receive it and should he be in the $50,000 to $60,000 bracket, his loss entails a net penalty of only $256.76. This is only 3.4 per cent of the $7500 benefit to the hospital fund. In other words, his sacrifice of $256.76, which otherwise would be available for living, is only one thirtieth of the benefit to the hospital.

Investment in hospital improvements, with the actual construction undertaken either now or in the future, is not antagonistic to the letter or the spirit of patriotic behavior. However, lest it be imagined that any of the foregoing suggests "beating" the government out of money needed for the prosecution of the war—and on that account is unpatriotic or even antisocial—let the following considerations be pondered.

First, hospital expansion will probably not even be contemplated when it is not needed; solicitation of funds for a needless purpose either will not be undertaken or, if attempted, will fail almost completely. When hospital expansion is truly needed, it is vital to the war effort. Witness the Lanham Act under which the federal government is helping community hospitals expand to meet demands for service augmented by the war. Who will charge that the government is guilty of uselessly diverting war funds?

From a purely economic point of view, hospitals do not pocket funds

but, in both maintenance or expansion, distribute the money to suppliers or contractors within the framework of governmental regulations. The profits made by the contractors, the wages they pay to their employes and the profits made by their suppliers are in due course taxed to produce revenue.

Hospitals are like commercial distributors or middle men except that they serve without profit. They do not, indeed cannot, hoard wealth; and, under existing conditions, only hoarding and waste deplete potential war funds.

One can short-circuit the discussion by supposing that each contributor who saves taxes by deductions for gifts invests these savings in war bonds, either to restore the capital used to make the gift or to add to capital security if the gift is made out of income. Then, there can be no argument.

Furthermore, to meet the last possible objection, that the hospital cannot, or should not, build now, the funds contributed to the hospital can be held in war bonds until it is seemly to reinvest the money in hospital modernization, improvement or expanded capacity.

It is thus both fair and safe to assure the overly conscientious patriot that he is being not unpatriotic but doubly patriotic in subscribing to his hospital's capital fund.

Facts are not enough. Unless hospitals take advantage of this situation their benefits will be purely accidental and probably insignificant.

First, the hospital should develop a proper definition of its case—its needs (the public's needs, of course), its plans and the benefits that will accrue from the realization of these plans.

Next, this case must be systematically, adequately presented to the hospital's constituency. Such a presentation almost necessarily will involve some campaign procedure. This need not even resemble, outwardly, the general, widespread community chest type of drive. It may be, and in many instances probably should be, of the less obtrusive kind, scheduled over a longer term. There are, however, no satisfactorily productive substitutes for the two essentials of campaigns, which are, according to their broadest definitions, organization and interpretation.

The opportunity exists for voluntary hospitals, with legitimate and urgent needs to make an auspicious start at solving what is by far the most difficult problem involved in any program of expansion or improvement—the assembling of the necessary funds.

"For the Duration"

TIMES have changed—as these regulations that were put into effect at Stanford University Hospitals on October 1 indicate. They are designed to save the time and strength of over-worked nurses and have proved satisfactory, says Anthony J. J. Rourke, superintendent.

Time Savers for Nurses

NURSES' BEDSIDE NOTES

The usual procedure of keeping nursing bedside notes will be discontinued. On and after Oct. 1, 1942, nurses will make bedside notes only when specifically ordered by the physician or when some definite change or serious symptom has occurred in the patient.

PATIENTS' TEMPERATURES

Present regulations regarding the periodic charting of temperatures will be discontinued. On and after Oct. 1, 1942, temperatures will be taken twice daily: once during the morning hours from 7 to 9 and once during the afternoon hours from 4 to 6. When a record of patients' temperatures is desired more often than this, they will be taken on written order of the physician in charge of the case.

PATIENTS RETURNING FROM OPERATING ROOM

Patients will be returned to their beds on gurneys from the operating room except when a special order is written by the doctor in charge of the case. In those cases in which patients should be returned by bed, such information before operation will allow the bed to be taken to the operating room floor in the first instance, thereby saving one round trip of the elevator.

BATHING PATIENTS

The usual daily bathing of patients cannot be continued. Patients will be bathed in bed only as often as necessary, and patients will be requested to bathe themselves as soon as their condition warrants such requests.

What Every Administrator Should Know About the

VICTORY TAX

ROBERT PENN

CERTIFIED PUBLIC ACCOUNTANT
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AN UNUSUAL feature of the new revenue act is the section dealing with Victory tax on individuals. This tax is effective on incomes beginning January 1.

Briefly, the Victory tax will be collected at the source through deductions from employes' compensation over $12 per week. Exempted from withholding are wages paid to farm labor, military and naval service, casual labor, domestic service in a private home, college club or dormitory and service outside of the United States. No distinction is made in connection with withholding of the tax as between married and single persons. Employers responsible for withholding the tax are required to file returns and to pay the tax quarterly. Receipts for the taxes withheld must be furnished by the employer to the employe.

The term "wages" under the act means "all remuneration (other than fees paid to a public official) for services performed by an employe for his employer, *including the cash value of all remuneration paid in any medium other than cash. . . .* " It is thus evident that other compensation to employes, such as room, board, laundry or any other form of maintenance, must be valued in some reasonable manner in order to compute the amount of the Victory tax to be deducted. Hence, it is apparent that with few exceptions all employes of hospitals will be subject to the tax.

The amount to be withheld by the employer on and after January 1 is 5 per cent of the amount by which the wages or salaries exceed: weekly, $12; biweekly, $24; semimonthly, $26; monthly, $52; quarterly, $156; semiannually, $312, and annually, $624.

The employer may elect to withhold the tax in accordance with one of the following tables which will eliminate many computations.

The act provides that "every person required to withhold and collect taxes under this part shall be liable for the payment of such tax and shall not be liable to any person for the amount of any such payment." The act further provides that the employer shall "make a return and pay such tax on or before the last day of

WAGE BRACKET WITHHOLDING TABLE

For Weekly Pay Roll Period			*For Biweekly Pay Roll Period*			*For Semimonthly Pay Roll Period*			*For Monthly Pay Roll Period*		
Wages Over	*Not Over*	*Amount of Tax to Be Withheld*	*Wages Over*	*Not Over*	*Amount of Tax to Be Withheld*	*Wages Over*	*Not Over*	*Amount of Tax to Be Withheld*	*Wages Over*	*Not Over*	*Amount of Tax to Be Withheld*
$12	$16	$0.10	$24	$30	$0.10	$26	$30	$0.10	$52	$60	$0.20
16	20	.30	30	40	.50	30	40	.40	60	80	.90
20	24	.50	40	50	1.00	40	50	.90	80	100	1.90
24	28	.70	50	60	1.50	50	60	1.40	100	120	2.90
28	32	.90	60	70	2.00	60	70	1.90	120	140	3.90
32	36	1.10	70	80	2.50	70	80	2.40	140	160	4.90
36	40	1.30	80	100	3.30	80	100	3.20	160	200	6.40
40	50	1.60	100	120	4.30	100	120	4.20	200	240	8.40
50	60	2.10	120	140	5.30	120	140	5.20	240	280	10.40
60	70	2.60	140	160	6.30	140	160	6.20	280	320	12.40
70	80	3.10	160	180	7.30	160	180	7.20	320	360	14.40
80	90	3.60	180	200	8.30	180	200	8.20	360	400	16.40
90	100	4.10	200	220	9.30	200	220	9.20	400	440	18.40
100	110	4.60	220	240	10.30	220	240	10.20	440	480	20.40
110	120	5.10	240	260	11.30	240	260	11.20	480	520	22.40
120	130	5.60	260	280	12.30	260	280	12.20	520	560	24.40
130	140	6.10	280	300	13.30	280	300	13.20	560	600	26.40
140	150	6.60	300	320	14.30	300	320	14.20	600	640	28.40
150	160	7.10	320	340	15.30	320	340	15.20	640	680	30.40
160	170	7.60	340	360	16.30	340	360	16.20	680	720	32.40
170	180	8.10	360	380	17.30	360	380	17.20	720	760	34.40
180	190	8.60	380	400	18.30	380	400	18.20	760	800	36.40
190	200	9.10	400	420	19.30	400	420	19.20	800	840	38.40
200	...	$9.40 plus 5% of the excess over $200.	420	440	20.30	420	440	20.20	840	880	40.40
			440	460	21.30	440	460	21.20	880	920	42.40
			460	480	22.30	460	480	22.20	920	960	44.40
			480	500	23.30	480	500	23.20	960	1000	46.40
			500	...	$23.80 plus 5% of the excess over $500.	500	...	$23.70 plus 5% of the excess over $500.	1000	....	$47.40 plus 5% of the excess over $1000.

the month following the close of each quarter of each calendar year. Every such person shall include with the final return for the calendar year a duplicate copy of each receipt required to be furnished under section 469." The employer shall also keep records and render statements required by the commissioner.

Section 469 in connection with wages states that the employer "shall furnish to each such employe in respect of his employment during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, on the day on which the last payment of wages is made, a written statement showing the period covered by the statement, the wages paid by the employer to such employe during such period and the amount of the tax withheld and collected under this part in respect of such wages."

The penalty for a false or fraudulent receipt or for failure to furnish a receipt is a fine of not more than $1000 or imprisonment for not more than one year, or both. The employer may also be subject to a civil penalty of $50. The commissioner may grant a reasonable extension of time (not exceeding thirty days) for the furnishing of the receipt to the employes.

It is now essential for all institutions to maintain detailed pay roll records in connection with all employes subject to the tax. This will, no doubt, increase the work in the office considerably, but it can be reduced to a minimum by use of visible record systems and proper procedures.

CONSERVATION

Depends Upon Cooperation

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IT HAS been proved again and again that to put a program of conservation into effect successfully, one must obtain the cooperation of all persons concerned, and that can best be done upon a basis of understanding. No one will bother to help unless he knows all the whys and wherefores. Therefore, at the University Hospitals of Cleveland we have been issuing a chatty *News Letter* at frequent but unstated intervals explaining the reasons for the lack or scarcity of drugs, cotton goods and other supplies.

We have also been using this letter to apprise our staff of the rise in prices. The result has been most gratifying in every respect. To quote only two examples: Since the *News Letter* reported the cutting of from 5 to 8 bolts of gauze a week to supplement reclaimed material, no gauze has had to be used for this purpose. Our alcohol consumption has been reduced 50 per cent. We believe our *News Letter* is of material benefit in winning our campaigns.

Women's and children's clubs ughout the city are supplying us bags made of newspapers, replacing the kraft paper bags for bedside use.

A bottle and ointment jar salvage campaign is continuing to be of great help to us. All containers are delabeled and scrubbed before being brought to the pharmacy. They serve numerous purposes, as follows:

1. Ointment jars for pharmacy use.

2. Gallon jugs for constant drainage and suction bottles.

3. Mineral oil bottles for urine specimens.

4. Prescription and dropper bottles for pharmacy use.

5. Litmus paper bottles for tablets.

6. Mayonnaise jars for sterile packing, applicators, tongue blades in the supply room.

Rubber economies that are proving satisfactory include:

1. Sewing patches on rubber draw sheets where soft spots appear.

2. Converting old intravenous tubing to tourniquets and also using it for irrigation purposes.

3. Demoting larger bore constant drainage tubing to irrigating cans.

4. Substituting household for surgical gloves for cleaning and for the bedside care of isolated patients with open lesions.

5. Using synthetic rubber rectal tubes. The length of service of these tubes offsets the additional expense many times over.

As a timesaver we have issued to the nursing units the smallest and brightest colored bonbon cups available to substitute for medicine glasses in serving tablet medications. Much less time is spent in washing medicine glasses and the breakage has been greatly reduced.

To conserve ointment tubes, we have discontinued the use of shaving cream for surgical preparations, using soap solution instead. Cold cream is issued only in jars to the nursing units.

The operating room discovered that the metal ends of adhesive packages serve admirably for needle holders in the sterilizers if holes are punched in them.

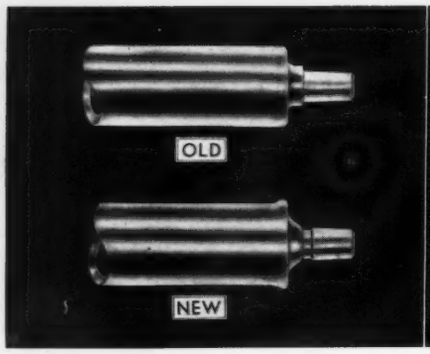
The heating elements of old inhalators make satisfactory hot plates.

Chemical heating pads to which a tablespoon of water is added may have to replace hot water bottles.

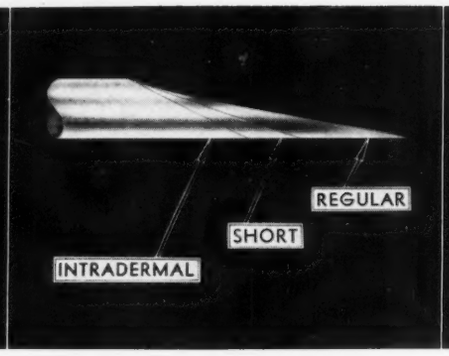
We have also found that razor blades can be satisfactorily sharpened by rubbing both sides of them against the inside of a smooth glass tumbler. We have reduced our consumption from 500 to 200 every two weeks.

The propaganda to conserve specified supplies for the war effort has aroused an interest toward protecting all our resources. The storeroom orders from all divisions have markedly and spontaneously decreased, including the amount of breakage. Apologies and explanations frequently accompany requisitions.

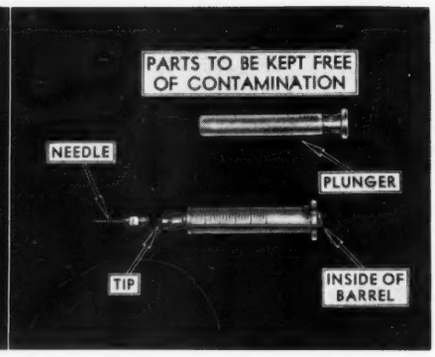
TEXT 1



The old type of syringe tip compared with the new. Construction eliminates score marks and consequent breakage of the tips.



The section of the film that describes manufacture of the syringe tip demonstrates these three standard needle bevels.

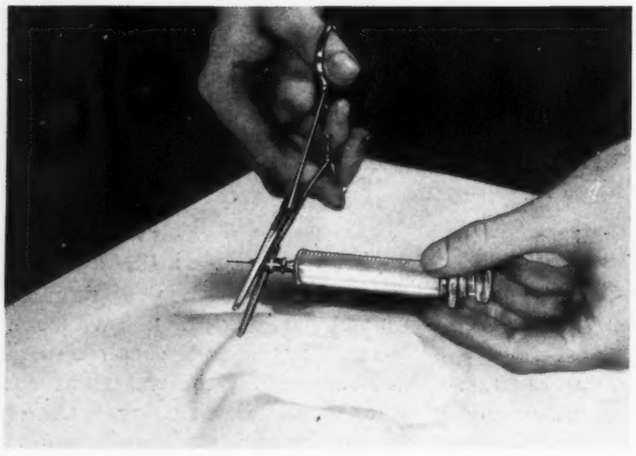


Parts that must be kept free from any possibility of contamination in assembling the syringe plunger and needle for use.

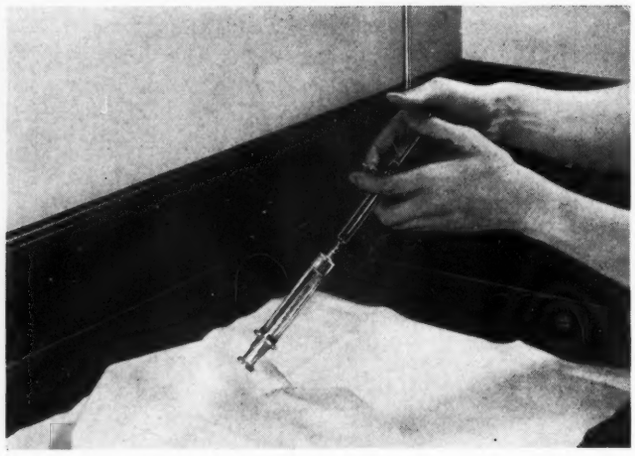
TEXT 2

The second section of the film demonstrates proper care of hypodermic needles and syringes and methods of cleansing, sterilizing and preventing breakage. The first step in cleaning, as shown above, is: Rinse in tap water, scrub with green soap, rinse again.

Second step in cleaning: Rinse again in clean water and brush thoroughly to remove all traces of soap. Syringes should be rinsed in at least three changes of water. If they are used for blood work the last rinse should be made in distilled water.



The methods of solving the problem of "stuck" syringes are also included in the second section of the film. It is pointed out that stuck needles and syringes can be avoided. When forceps are used, the barrel, not the forceps, should be twisted.



Removing a "stuck" plunger with the syringe opener. The opener is applied after the air space has been filled with water through the tip of the syringe. Note the position of the hands. Both should be on the opener as steady, gentle pressure is applied.

Teaching by SIGHT

COLOR, SOUND, ANIMATED PHOTOGRAPHY AND CAREFUL PLANNING HAVE INCREASED THE EFFECTIVENESS OF MEDICAL TEACHING FILMS TO SUCH AN EXTENT THAT THE HOSPITAL EDUCATIONAL PROGRAM THAT DOES NOT INCLUDE THEM CANNOT BE CALLED COMPLETE

MALCOLM T. MacEACHERN, M.D.

THE motion picture as an aid in the teaching of medicine and allied arts and sciences began in the days of World War I. War necessities were an impetus to its development. The pictures produced in the early days were, however, no better than might be expected under haphazard conditions. Some were produced merely to publicize a commercial product or an individual physician. Ethical principles were not always observed and educational standards averaged fairly low. There was no way of evaluating them.

When the American College of Surgeons started its program of supervision, review and approval, which promised to bring order out of chaos, the keenest interest was shown. The approval list issued each October remains the accepted guide for the selection of teaching films.

Out of approximately 2500 or 3000 medical motion pictures reviewed since 1926, approval has been given to some 600 films with an aggregate of 900 reels. Committees are specially selected for the type of film under review. A surgical film is reviewed by a committee of surgeons known to be competent in the particular subject portrayed. In medicine and the various specialties the committee is selected in the same way. If the film involves physiology, leading physiologists of the four approved medical schools in Chicago are called in to review it. Films for hospital personnel are reviewed by persons who are highly trained and experienced in the specific field that has been covered.

An example of the advantage of consultation with a committee of specialists during production is a new series of films entitled "Hypodermic Syringes and Needles—Their Care and Function." Three parts of this series, each having two reels and taking from twenty to twenty-five minutes to show, have been finished and are available. They are directed mostly to nurses and student nurses, although interns, physicians and others will benefit by the information given concerning the evolution and proper use of syringes. An advisory committee of operating room supervisors and nurses was appointed by the American College of Surgeons to cooperate in preparing this film, which is being produced by Becton, Dickinson and Company.

This film not only is of great teaching value for students, but is exceedingly timely as one of its aims is conservation. Text 1 begins with an introductory subtitle relating the attempts first made at the beginning of the last century to utilize the skin as a medium for the introduction of remedies. Drugs were rubbed into a previously made incision. Later, syringes were introduced, designed to deposit the drug or remedy beneath the skin. The first two scenes show close-ups of the earliest crude designs of syringes. Succeeding scenes show developments, including syringes with a glass barrel and rubber or asbestos pistons, up to 1897 when Luer, an instrument maker in France, made the first syringe with a tapered tip to which a needle could be securely fastened.

In contrast to the early Luer syringes is the modern Luer Lok syringe, and a subtitle tells of the wide range of syringes and needles especially designed for specific functions that are obtainable today. Then the process of manufacture is pictured, showing the infinite care with which the instruments are made and the thoroughness of the inspection to which they are subjected. A feeling is instilled that they are entitled to equal care when in use.

Text 2 portrays care of hypodermic syringes and needles, approved methods of cleansing and sterilization and common causes of breakage and their prevention. The details of rinsing, brushing and drying are shown. Solution of the annoying problem of "stuck" syringes is presented, showing exactly how the syringe opener is employed. There is a demonstration of technics of removing stains. How to test the temper of needles and how to sharpen them are shown in close-ups. Finally, a test chart, or performance record, is suggested as a means of determining accurate syringe costs.

Text 3 portrays function, use and application of syringes and needles. It demonstrates the procedures that are of particular interest to nurses, such as intradermal, intramuscular and intravenous injections. A typical scene shows the procedure of placing a tourniquet on the patient's arm in preparation for drawing blood for diagnostic tests; the patient opening and closing his fist to produce engorgement of the veins distal to the tourniquet, and finally the operator palpating the vein to determine the site of injection, cleaning the area over the vein and inserting the syringe. An animated diagram shows how the needle enters a vein and is then threaded up into it.

It is made clear that although a syringe similar to that used in venapuncture, with an eccentric tip, is well suited for intravenous anesthesia, this and other procedures, such

as blood transfusion and spinal puncture, are usually performed or directed by the physician.

A fourth text in this series, a two part film dealing with intravenous and spinal anesthesia, is now under way and a fifth is planned on the technics of blood transfusion. Succeeding films will be on other special procedures.

Motion pictures are of little value as a self-sufficient educational method, but they supplement the lecture, the demonstration, the textbook and the medical, hospital and nursing publications. Close-up views, slowed motion and animation make possible a better grasp of the exact way to hold an instrument and the precise manner of using it than other mediums can do alone, and the result is a speeding of the learning process that is especially urgent today. There is stimulus, also, in combining a medium that has associations with glamour and romance with the traditional elements of classroom and laboratory teaching, even though the subject matter of the film may be prosaic syringes and needles.

An interesting teaching film, both in itself and from the point of view of its sponsorship, is the new presentation by Edgar Bergen of Hollywood, called "The Nursing Arts." The procedures were supervised by the southern section of the California League of Nursing Education. Two reels, one on bedmaking and bed bath, the other on operating room technic, have been completed and are available. At one of the first showings to student nurses, the comment was that the picture was excellent for supplementary work, "giving the student a vivid conception of the practical application of the work that she has studied but not experienced." The film is outstanding from a photographic standpoint, and the nursing procedures are well and meticulously depicted.

Among the growing variety of agencies aiding in the production of medical teaching films are the visual education services of universities, hospitals, laboratories, scientific institutes, associations, foundations, insurance companies, departments of health, photographic equipment companies and manufacturers of drugs, operating room equipment and medical and hospital supplies. The subjects of approved films range from delicate eye operations to thoracoplasty in the treatment of pulmonary tuberculosis.

Some are highly technical, intended for the postgraduate education of the experienced surgeon; others are simplified for the enlightenment of the beginner and for hospital workers other than physicians who profit in their work by a general understanding of certain technics even though they do not perform them personally. Many of the films are of interest to all workers in health fields because of their elucidation of basic science facts.

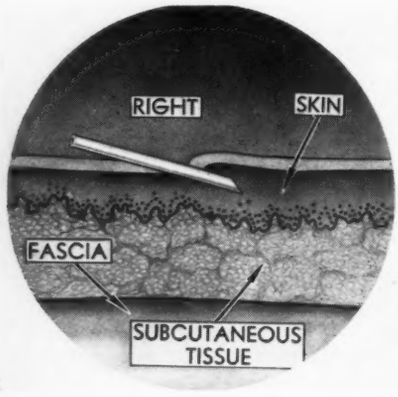
Medical teaching films have come a long way, yet they are only beginning to demonstrate their value. Color and sound have vastly increased their effectiveness, and the animated diagram is another fairly new technic that is being employed to excellent advantage. Planning is the element that has been most lacking in their preparation, but with the impetus of the war needs we may expect to see more completely rounded programs of pictures in series that portray a specific subject or procedure from all angles.

Eventually it will be possible to supplement practically every classroom lecture and laboratory demonstration with a motion picture. In the meantime, the films available and the new ones in preparation should be carefully considered in planning the hospital training program.

TEXT 3

1. Cross section showing position of the needle in making intradermal injection.

1



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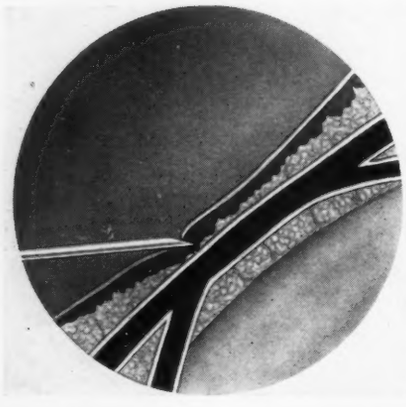
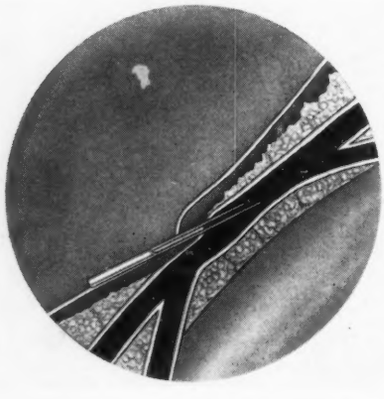


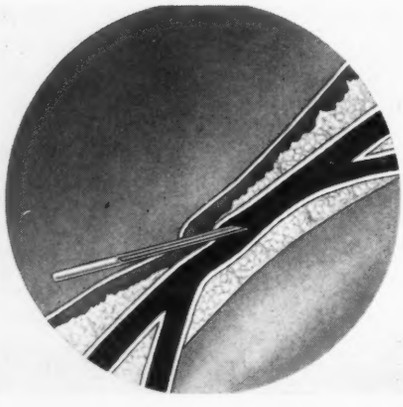
2. Vena puncture: Entering the skin.

3



3. Vena puncture: Entering the vein.

4



4. Third step in vena puncture: Aspirating to make certain the needle is in vein.

Lessons From the Boston Tragedy

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ASSISTANT ADMINISTRATOR
MASSACHUSETTS GENERAL HOSPITAL
BOSTON

THANKS primarily to their air raid protection training, the hospitals of Boston were far better prepared than they would otherwise have been to care for the victims of the disastrous Cocoanut Grove dance hall fire on November 28. In general, the methods of caring for these victims were the same in all hospitals. Every institution surprised itself by the skill and smoothness with which the overwhelming influx of patients was handled.

At Massachusetts General Hospital, the patients—living, dead and dying—were brought to the emergency ward, which just six days before had undergone a complete dress rehearsal on the procedure for receiving casualties. The victims of the fire came in even faster than could be expected in a major air raid.

Rates of Dead Unusually High

Unlike an air raid, the number of victims could not be anticipated from any similar experience. Certainly, the ratio of dead on arrival far exceeded the experience of almost any other disaster, civilian or military. War experience, both on the battle front and in civilian bombing, usually results in from three to five injured for every death. In this holocaust, the figures were reversed.

At 10:30 p.m. the head nurse of the emergency ward admitted three patients. She sensed something unusual and called for additional assistance even before the stream of taxis, ambulances and trucks appeared. Fortunately, since the shift of nurses occurs at 11 p.m., both the departing and oncoming shifts were retained and made smooth a job that might otherwise have suffered.

It seemed that almost at once residents, staff members and other doctors affiliated with the hospital appeared and shock treatment was started, especially intravenous fluids and plasma medications. Nurses provided blankets, handled patients and shifted them to the sixth floor of the White Building.

The fact that only one out of four persons was alive made it necessary immediately to plan for the dead. Massachusetts General is unique and fortunate in its "brick corridor," which is a vast room connecting several parts of the hospital. It is about 125 feet long and almost the same width. In two hours, there were 75 bodies under white sheets, neatly arranged in order and properly screened from the view of unauthorized persons. Police and guards were immediately posted, almost with the arrival of the first body, and at no time was a body left except in the presence of at least one and usually two guards.

It soon became obvious that the number of injured would be appreciable and that everything must be done to conserve nursing, medical and administrative effort. This need was anticipated almost at once and provision for evacuation of the entire sixth floor was made while the victims were being cleared through the emergency ward. In two hours 39 victims of the fire were in the beds—women on one side of the building and men on the other.

The rapidity with which the patients were brought in made any elaborate burn treatment impossible. Most of the burns were of relatively small body areas, often limited to those about the face, neck and upper chest. Burns of more than third degree were rare on both the living and the dead. The patients were treated with simple sterile ointment and pressure bandages. Oxygen was administered through anesthesia machines.

Eight operating rooms were available in half an hour after the first patient came in, but there were no fractures and no need for the surgical nursing team that collected itself out of the early night and was ready for anything.

The handling of patients on the sixth floor was well conceived and functioned perfectly. Because of the centralizing of all patients, a great many valuable and significant results were achieved.

1. Only one section of the hospital was disturbed. The morale of patients was maintained because they could neither see nor hear the increased activity.

2. An astounding amount of medical care needed for the best possible treatment of the patients was collected and available in one area. In these days of shortage of nursing and resident medical staff this made for minimum lost motion.

3. The emergency care of crises was anticipated and handled with a speed that probably would not have been possible if patients had been distributed throughout the hospital. For example, 36 hours after the patients were brought in there were occasions when emergency tracheotomies were essential and were done with only the slightest warning from the clinical progress of the patient.

Isolation Technic Enforced

4. Mask and gown technic was insisted upon and carried out perfectly both because no one was admitted to the sixth floor without proper authority and because no one could enter the ward without thus being protected.

5. Medically, the strict isolation of these patients gave an almost ideally controlled background for judging the final effectiveness of treatment and care of the patients.

6. All supplies, instruments, equipment and personnel borrowed from other parts of the hospital were easily recorded and their eventual return was markedly simplified.

7. Administratively, the plan was most successful. Visitors were absolutely excluded, even though the patients might be on the danger list for the first thirty-six hours.

The telephone operator and admitting office had only one place to seek

the latest bulletins on every disaster patient. These lists were compiled and complete by 3 a.m. At first, the admitting office would get reports on patients at about twenty minute intervals and, thereafter, every two hours except in the case of dangerously ill persons when the sixth floor was called on every query.

Strict carrying out of the medical orders was simplified. There was only one place to send supplies—only one place to consider as being in any way abnormal and demanding special administrative ruling.

The hospital received 114 victims, 75 of whom were either dead on arrival or died before they could be formally admitted to the hospital. Thirty-nine living victims were sent to the sixth floor. Five of these died in the first twenty-four hours; four were well enough to be taken home at the end of twenty-four or thirty-six hours, and five days after the tragedy 28 patients in various stages of illness remained.

The hospital learned a number of things that may be of benefit to others who find themselves facing a similar responsibility.

Many Deaths Caused by Gas

Disaster cannot be accurately forecast as to the number and type of casualties. In explosions the wounded and injured may be as high as 10 to 1 dead. In the Boston holocaust death appears to have resulted in most instances from respiratory poisoning, presumably from toxic materials in gaseous form distilled or resulting from the incomplete combustion of the decorations.

Unquestionably, the greatest single factor in the success of handling the Boston disaster was the preparation for air raids. A manual giving all major details, including the names of teams, their leaders and places for carrying on the care of casualties, had been released and studied over a period of months. A daily air raid list was made up each morning so that every one of 50 persons on warden duty would be available at any time. Drills had been carried out to lead up to the smoothly working organization which proved itself in every Boston hospital.

In addition to personnel, the problem of supplies must be considered. The hospitals would have been much less well supplied with nursing and medical equipment if civilian defense had not been a current problem. As it was, in this instance, probably every Boston hospital would normally have had enough supplies, but it is doubtful whether they would have been as easily found or in such good condition.

If one could forget the grief and tragedy for a moment, it was thrilling to see and hear the various units clicking smoothly into action without a general alarm having been sent out. Every department did its share. Professional and lay staff members came to the front without fanfare. They found jobs or, what is more remarkable, they assigned themselves to jobs that were for the benefit of patients. The task of guiding visitors and relatives to identify bodies was assumed by volunteers. The dietary department made and distributed gallons of coffee to anyone who wanted it—no questions asked, no limit to the amount.

In practicing for air raids, the social service department had assumed the responsibility of recording data on shifting patients, especially those who might be able to be taken home, to make room for disaster victims, and of notifying friends and relatives. Patients came in far too fast to permit much record keeping and the main problem was to care for the living and get them to the ward. Names and addresses were taken at the best time possible, being always secondary to the care of the patient. Even with these limitations, the ward lists contained no serious errors and only a few of any kind.

The newspapers were clamoring for information. It was a public accident and a public problem. The press was courteous and the hospital felt that it deserved all possible cooperation. The usual policy of consulting the wishes of the patient was waived. There was nothing to hide and friends and relatives near at hand or across the continent had a right to know all they could. Considering that the patients were spread throughout all the hospital facilities of the city and the dead filled morgues and empty stores adjacent to the scene of the disaster, the information was almost error free. This well illustrates that rules are made to be broken.

The thoroughness of the police cooperation, especially in taking over the responsibility for the identification of bodies, relieved the hospital of a terrific responsibility. The police rules were simple and sound.

Several unobtrusive but skilled officers were detailed to make certain that persons attempting to identify bodies really knew the victims and were interested in the disposal of the bodies. When these questions were made a matter of police record, including proof of identity of the claimed friend or nearest of kin, this person was sent to the medical examiner for a death certificate which was then given to the mortician who called for the body. The bodies were not released until a careful checking of papers and complete identification of undertakers had been done.

Victims' Possessions Guarded

The policy on the care and responsibility for valuables was one of great significance. For persons who were admitted to the ward, the hospital made every effort to carry out its usual system of protection of valuables. The possessions of the dead were protected by establishing guards consisting of not less than two persons, preferably policemen.

One never knows in advance how many dead are to come. The large brick corridor was used because it could easily hold 100 bodies. Bodies were arranged in rows, parallel to the length of the room. While this system was adequate, in the future all bodies should be segregated by sex. This reduces the amount of traffic. The bodies should be placed about a foot apart, parallel to each other at right angles to the passageway with the heads nearest the passage. Faces are always the best identification and they can be more easily and quickly reviewed this way. Clothing is the next best means and its value is not lessened by this plan.

At the press interview several days after the disaster the director of the hospital, with the enthusiastic support of his trustees and the press, announced that there would be no charges of any kind for hospital and emergency care rendered to the victims. The medical staff simultaneously announced the same public contribution. In spite of the fact that some of the patients could and probably would want to pay, no charges are being entered.

Patients, staff and public must be protected against

COMMUNICABLE DISEASE

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IN LARGE communities with crowded living conditions, the peak periods of the seasonal fluctuations of acute communicable diseases have resulted in a sufficient number of cases to warrant the maintenance of special hospitals. In many smaller communities, however, communicable diseases have had a nuisance value only and have been ignored.

With our present knowledge of bacteriology and of the transmission of diseases, this condition need not continue. Acute communicable diseases can be treated in general hospitals under the special safeguards of proper construction, adequate sterilization equipment and a sufficient force of trained personnel. Communities that lack a special hospital for acute communicable disease cases are justified in demanding that their hospitals make provision for the treatment of these.

I do not mean to imply that all general hospitals should establish acute communicable disease services. Where special hospitals exist, they should be used to their fullest extent, and in cities in which the incidence of acute communicable diseases is high the special hospital is preferable.

Conversely, it would not be economically sound for the small community to build a special hospital for acute communicable diseases. Such institutions are costly to construct and to maintain.

Before any building or major reconstruction venture is undertaken, the needs of the community should be studied. In the case of acute communicable diseases, the following factors should be considered:

1. Communicable diseases occur in cycles that have yearly trends and they vary over a series of years; hence, to obtain a picture of present needs, the experience of at least ten previous years should be studied. A comparison of the statistics of two successive years, as practiced by general hospitals, is valueless in the case of communicable diseases. If the statistics of two years must be compared, alternate years give a truer picture.

2. The quarantine regulations of the local health department are important. The present trend, at least in the larger cities, is to decrease the quarantine periods. Conditions that are true today may be quite different tomorrow.

3. All patients with communicable diseases do not require hospitalization. In cities, the proportion of patients requiring hospitalization is larger than in towns and villages because most people live in apartment houses or hotels that do not allow for proper isolation and because of the numerous institutions for child care. In towns and villages, more people live in private houses and can be quarantined at home.

In planning a communicable disease service, whether as a special hospital or as part of a general hospital, at least one third or, better still, one half of its capacity should be in private rooms and the remainder in small wards of not more than four beds each. Patients must be segregated by disease, by age groups and by sex. The ward beds should be separated by partitions or cubicles, which should be installed in such a manner as to form a visitors' corridor. In this way, the visitor can be separated from the patient by a metal and glass partition. There must be a generous supply of lavatories. The ideal setup is a scrubup sink in each private room and one in each four bed ward.

In all building and remodeling operations concessions must often be made and variations of the ideal may have to be worked out. However, it should always be borne in mind that too many concessions must not be made when establishing an acute communicable disease service. The safety of the patient and of the personnel depends upon the rigid following of a special technic.

The sterilizing equipment should be adequate; steam sterilizers must be provided for bedpans and other utensils and for dishes and glassware.

The supervisor of the service should be a graduate nurse with special training in acute communicable diseases. She should have the ability and the personality to see that the physicians, nurses and attendants carry out the special technic at all times.

The attending medical staff will be drawn from the regular medical staff of the hospital. Interns and residents should be assigned to the service for specific periods of time. They may rotate from the pediatric and, probably, also from the medical services.

Relations with the department of health must be close and cooperative at all times.

If a communicable disease service is planned for a general hospital, this service may be accommodated in a separate building or in a sepa-

rate wing under the general administration. If neither of these arrangements is possible, a floor, a ward or a group of private rooms can be set aside for acute communicable disease patients.

Not all general hospitals need establish communicable disease services. However, all hospitals owe a duty to their patients not to expose them to communicable diseases. The best admitting room procedures and the greatest vigilance on the part of the medical staff in weeding out patients affected with communicable diseases do not completely solve the problem. Therefore, every hospital should provide a minimum number of isolation rooms as required by the local health department. These facilities can be used to accommodate doubtful cases, until a diagnosis is made, and definitely diagnosed cases of contagion pending transfer to the special hospital.

The health department regulations concerning report, isolation and quarantine of communicable disease cases should be studied. Certain services, such as the pediatric, newborn nursery, tuberculosis and venereal disease, require the provisions of special facilities and the practice of a special technic.

Pediatric Service

The pediatric service should be planned somewhat like an acute communicable disease service, with isolation rooms, cubicles, lavatory facilities and sterilization equipment. At least half of the accommodations should be for isolation. Children should be isolated for at least sixteen days. After the isolation period, those who have not been discharged may be transferred to the wards. Visiting on the pediatric service should be controlled. It is best to permit only the parents or guardians to visit. Under no circumstances should children be permitted to visit in pediatric wards. Visitors should be gowned and kept away from contact with the patients.

The supervising nurse of the pediatric service should be a graduate nurse who has taken postgraduate courses in pediatric and communicable disease nursing. The nursing staff should be ample. If there are student nurses, the ratio should be 1 to 2; with an all graduate staff, 1 to 4 may suffice.

Physicians and nurses on the pediatric staff must be alert to detect early cases of communicable diseases. There should be a daily inspection of all patients.

New-Born Nursery

The New York City department of health has established regulations governing new-born nurseries. The sanitary code states that "every lying-in institution shall maintain in good order one or more properly equipped nurseries which shall be an integral part of the maternity service. Separate isolation quarters shall be maintained at all times for the isolation of ill or infected babies; there shall be a minimum of 6 inches between bassinets; where a carrier system is used, the bassinets shall be so arranged that the face of the infant is at least 6 inches below the level of the top of the bassinet. The suspension of bassinets on double tier racks shall be prohibited. The nursery and the isolation quarters shall be provided with running hot and cold water."

The regulations further require that the isolation facilities for premature infants shall be separate and distinct from the regular new-born nursery isolation quarters and that the care of one premature infant is equal to that of three full-term infants. "Not more than one unit of three premature infants shall be under the care of one nurse either day or night.

"The nursery linens shall be cared for separately from the general hospital laundry and shall be sterilized by boiling for fifteen minutes.

"The formula room or suite shall be a separate entity with adequate refrigeration and sterilization equipment.

"The nursing staff for the newborn and premature nurseries shall be separate from the regular nursing staff and under the supervision of a registered graduate nurse."

The regulations specify in detail the various technics to be observed in caring for the infants, in handling laundry and equipment, in preparing formulas and in controlling visitors.

Venereal Diseases

The venereal disease may be a primary or only a coexisting condition. Excluding patients on special venereal disease services, these cases are invariably scattered throughout the hospital. They may be found on the urological, the ear, nose and throat and the dermatology service. Staff alertness to diagnose these cases early is important, as is the institution of proper precautions to protect patients, nurses and attendants.

Vaginitis and ophthalmia, caused by the gonococcus, in children are dangerous. It is difficult to isolate these patients in a ward. The danger to other children may be eliminated by strict isolation in separate rooms with proper technic on the part of the nurse and physician and with adequate sterilization of clothing and contaminated equipment.

Pulmonary Tuberculosis

It is desirable that these cases be treated in a special hospital or on a special service of a general hospital. The treatment in many instances involves the use of special facilities and equipment for chest surgery. In all cases, high caloric and high vitamin diets, a cheerful environment and the practice of a special technic to prevent the infection of nurses, attendants and others should be provided. Finally, in all hospitals there must be staff alertness to detect the undiagnosed case of pulmonary tuberculosis on the general wards.

Cross-Infections

Regardless of whether the communicable disease patient is cared for in a special hospital or in a wing, floor or private room of a general hospital, it is the duty of the administrator to assure: (1) adequate medical and surgical care plus specialized treatment for the communicable illness; (2) protection of the patients from cross-infections, and (3) protection of hospital personnel and the public.

A cross-infection, often called secondary infection, is the development of a second communicable disease in the same patient. The exposure to the second disease may have occurred before or after hospitalization of the patient. It is the exposure after hospitalization that concerns the hospital.

Methods of prevention of cross-infections include physical barriers, medical aseptic technic, immunization of exposed susceptible patients and air sterilization.

Physical Barriers: Isolation rooms, cubicles and screens serve to decrease droplet infection by coughing and sneezing, prevent personal contact between patients and prevent the passing of objects from one patient to another.

Medical Aseptic Technic: The first principle of the technic is that communicable diseases are spread from one patient to another by contact only and are not air-borne. Contact may be direct, as when one person touches a person suffering from a communicable disease or is coughed or sneezed upon by a patient; or it may be indirect, as when one touches an object that has been touched either by the patient or by something else that the patient has touched.

For instance, a nurse touching the bed of a chickenpox patient then carrying a tray to a measles patient without first changing her gown and scrubbing her hands may easily carry chickenpox to the measles patient.

It is not strictly true that communicable diseases are not air-borne. Besides the spread by cough droplets, which may extend 5 feet from the source, moist dust particles can certainly spread streptococci. It is quite possible that dust particles may carry the virus of chickenpox and measles —the two diseases that are notoriously highly communicable—an indefinite distance, particularly if there is a draft or a breeze. However, the contact theory has given us a practicable method of preventing cross-infections to a great extent.

Medical aseptic technic, therefore, involves the complete isolation of the patient and all objects within 5 feet of his head, the prevention of unnecessary contacts between the patient and other people and, where contact does occur, its immediate counteraction by so-called concurrent disinfection.

The final principle is that in the presence of contagion secondary infections, particularly of the upper respiratory tract, are usually as contagious as is the primary disease. For example, a measles patient who is suffering from a bronchopneumonic infection should be as rigidly isolated from another measles patient as if the secondary disease were scarlet fever rather than bronchopneumonia.

The details of a communicable disease technic will vary with different conditions. Each hospital director should evolve a technic that is satisfactory to the conditions of his institution. The important part is to have the instructions written and available for the guidance of the workers.

The instructions or standing orders should incorporate details relative to the following:

1. Washing of hands by nurses, physicians and others after every contact with the patient or with any contaminated article before performing any other duty.
2. Wearing of gowns and instructions in their proper use.
3. Wearing of face masks when indicated.
4. Treatment of linen and other articles coming in direct contact with the patient or his belongings.
5. Cleaning and sterilizing of utensils and other contaminated objects.
6. Rules regarding visitors to communicable disease patients.
7. Rules regarding outgoing mail and receipt of food and toys for the patients.
8. Proper cleansing of premises vacated by communicable disease patients.

Air Sterilization: In accordance with the theory that bacteria expelled from the nose and throat by coughing or sneezing gravitate quickly downward and stay where they land, partitions only slightly higher than a person's head or at distances of only a few feet were thought to prevent the spread of respiratory diseases. Recently, it has been demonstrated that most of the expelled droplets evaporate before reaching a resting place and the bacteria themselves float away as tiny particles of living dust to drift long distances.

Installations of germicidal lamps in several large hospitals specializing in the care of infants have resulted in a reduction in the transmission of respiratory diseases and of acute communicable diseases from cubicle to cubicle. Germicidal lamps have also been found effective in operating rooms, providing insurance against air-borne wound infections.

Immunization of Exposed and Susceptible Patients: For this purpose, we are interested in acquired passive immunity such as is produced by the injection of antitoxin and convalescent serums. Antitoxin should not be injected needlessly. Knowledge of the reactions to the Schick and Dick tests of exposed patients is important. Patients with negative reactions need not receive prophylactic treatment upon exposure to disease.

Protection of Personnel

Hospital authorities are responsible to a certain extent for the health of their employes. Moreover, it is to the hospital's interest to prevent occupational illnesses of employes. Many states have included occupational diseases in workmen's compensation acts. The courts require careful proof in cases involving liability for infections spread by contagion.

The hospital must show that every reasonable precaution was taken to isolate the infected patient and that it employed the technic practiced by the hospitals in the community under similar instances, (Hayt and Hayt). There have been a number of decisions rendered against hospitals in favor of employes who became infected with communicable diseases.

The preemployment examination should include a physical examination; an x-ray examination of the chest or a Mantoux test followed by a chest x-ray, if the Mantoux test is positive; Widal, Wassermann, Dick and Schick tests, and other indicated laboratory examinations. Reexaminations should be made annually except in the case of employes in close contact with patients having pulmonary tuberculosis who should be reexamined every three months.

Employes found to be susceptible to diphtheria and to scarlet fever should be actively immunized before being assigned to work in close contact with patients having these diseases. Those in close contact are nurses, interns, resident physicians, nurses' aides and hospital attendants and, occasionally, porters, technicians and laboratory workers.

All employes working on communicable disease services should have competent supervision, should be given detailed and written instructions of the medical aseptic technic and reasons therefor and should show proficiency in performing the technics.

Health Center for 6000

White man's medicine puts the "Indian Sign" on disease at the new hospital of the Pima Agency

J. R. McGIBONY, M.D.

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U. S. DEPARTMENT OF THE INTERIOR, WASHINGTON, D. C.

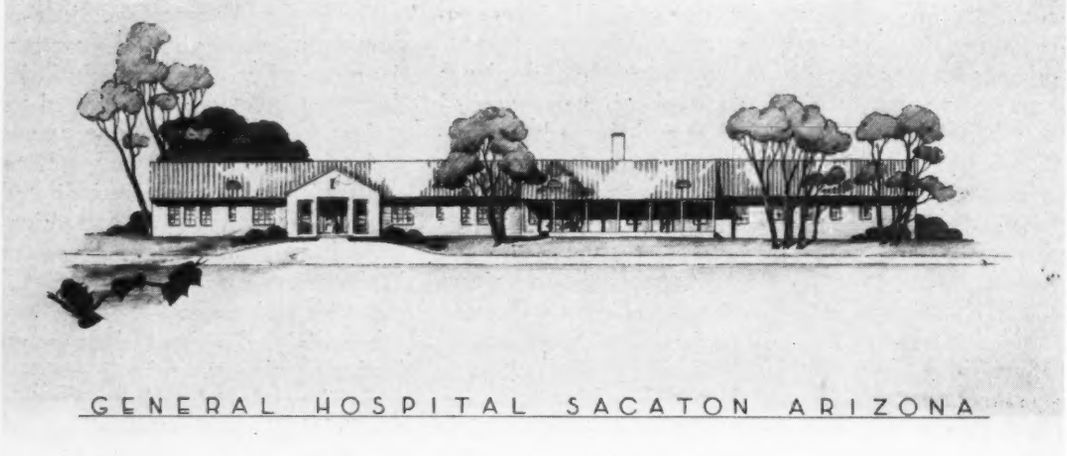
THE hospital as a health center is the basic theme of all Indian Service hospitals, and making effective use of a background of experience gained through the construction and administration of 98 hospitals scattered from the Atlantic Seaboard to Point Barrow, Alaska, the Office of Indian Affairs has recently constructed a unit that is unique in annals of Indian medical care.

This latest addition to the service, located at the Pima Agency, Sacaton, Ariz., 45 miles south of Phoenix, replaced an antiquated frame structure, erected in 1916, which contained two large wards, each with a capacity of about 15 beds.

The new building provides three 2 bed, three 3 bed, three 4 bed and two 6 bed rooms for a total of 39 beds and a nursery with seven cubicles for bassinets. One of the 2 bed wards and one 3 bed ward are separated from the main hospital by corridor doors and contain their own utility room in order to serve as isolation units.

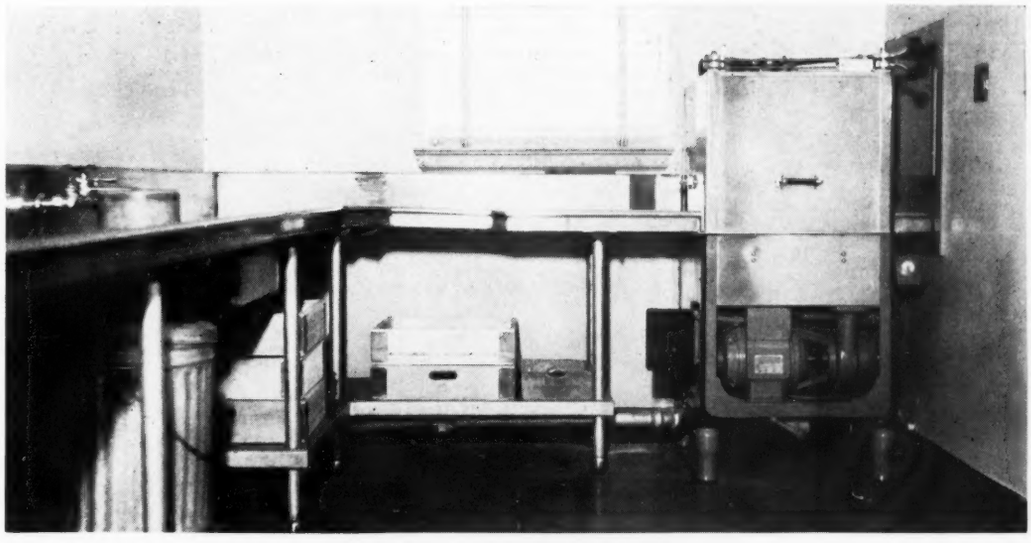
Since the hospital serves as a health center for the entire reservation, with an Indian population of approximately 6000, special consideration was given to design and placement of the out-patient department. The lobby serves as a waiting room. The entire wing can be closed off by corridor doors, preventing unnecessary traffic and visiting out of hours. Indians have a proclivity for wandering about to greet sick friends.

The admitting office and record room, examination and treatment room, laboratory, x-ray room and physician's office are located in the out-patient area. It was considered desirable to include a second physician's office, a dental unit and an

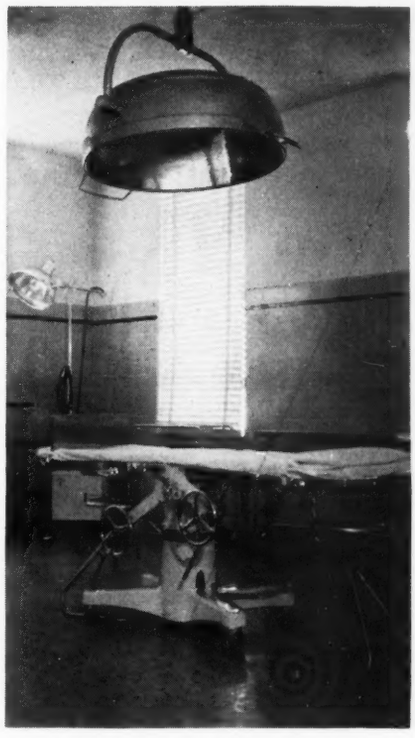


KEY TO PLAN

1—Lobby
2—Nurses' station
3—Admitting room
4—Clinic
5—Laboratory
6—Doctor's office
7—Supply storage
8—X-ray
9—Darkroom
10—Two bed ward
11—Three bed ward
12—Sterilizing unit
13—Four bed ward
14—Six bed ward
15—General bath
16—Drug closet
17—Utility room
18—Nursery
19—Formula room
20—Nurses' bath
21—Nurses' work-room
22—Sterilizing room
23—Operating room
24—Surgeons' scrubup
25—Surgeons' bath
26—Delivery room
27—Linen room
28—Soiled linen
29—Food cart alcove
30—Kitchen
31—Refrigerator
32—Preparation
33—Stores
34—Dishwashing
35—Staff dining room
36—Patients' clothes



The dishwashing machine is placed at an opening in the wall so that dishes are removed to clean dish room without being touched by the same employe who handled dirty dishes.



A corner of the operating room, showing operating table and light. Across the room are built-in cabinets and viewing boxes. Air conditioning brings relief from the glare of desert sun.

office for the public health nurse, but available funds did not permit us to do this.

The examining room, or clinic, was purposely made more than 20 feet in length and equipped with lightproof shades to provide better facilities for eye work. Darkroom arrangement eliminates the usual maze and provides storage space; a transfer cabinet saves many unnecessary steps for the x-ray technician.

Much thought was given the placement of the nurses' station which occupies the most nearly central location for most activities. From here, the nurse controls the entrance and out-patient department, and no hospital patient is more than 50 steps away.

The utility room serving the two wings is centrally accessible to each.

The nursery and formula rooms are combined and can be closed to visitors by corridor doors that separate the surgical suite from the remainder of the hospital. A 3 foot glass window permits the fond parents a view of their latest papoose in aseptic seclusion. To further the isolation of new-born infants, the nursery is divided into individual cubicles by metal and glass partitions, and each infant has its own clothes and supply cabinet within the cubicle. The top of the cabinet is counter high, linoleum covered for bathing and dressing. Individual basins will be furnished.

CONSTRUCTION DETAILS

GENERAL DATA: New 39 bed and 7 bassinet general hospital designed to serve the Pima Indian Reservation with a population of 6000.

CONSTRUCTION: Combination clay tile and concrete first floor slab. Wood ceiling joists and roof rafters. Pitched roof with cement-asbestos shingles. Exterior walls, precast gravel concrete blocks made on the premises, cement water paint exterior, plastered direct on interior. Windows, steel casement with hopper ventilators.

FLOORING: Operating suite, kitchen, dishwashing room, utility room, baths, tile; wards and other rooms, linoleum.

HEATING AND VENTILATING: Zoned, thermostatically controlled, forced warm air circulating system, oil-fired furnaces; high pressure boilers for sterilization and cooking. Designed for summer air cooling.

COSTS: Construction only, $131,600 or about 40 cents per cubic foot; equipment and furnishings, $17,000, estimated.

ARCHITECTS AND ENGINEERS: Construction Division, Office of Indian Affairs.

A feature of the plan is the dishwashing arrangement. Food is served at the bedside from hot food carts; soiled dishes are returned to the "soiled-dish room" where they are scraped and racked for the washer. The washer is placed at an opening in the wall, so that clean dishes emerge into a separate room, obviating the possibility of contamination by the individual who handles the dirty dishes.

Principal points in the building, physician's and nurses' quarters and the agency office are connected by automatic dial telephone. Each bed has included in its call-system outlet a radio connection to a centrally controlled set with phonograph and microphone attachments.

The entire building is heated during the mild winters by a zoned, thermostatically controlled, forced warm air circulating system from oil-fired furnaces. The heating system contemplates the circulation of a mixture of outside air and return air with a manually controlled ratio varying between 10 per cent and 100 per cent of outside air. As a welcome relief from the desert sun, the ducts carry refrigerated air during the summer. This is the first air conditioned hospital to be constructed by the Indian Service.

Also included in the construction program at Pima Agency are new quarters for nurses and attendants in addition to a cottage for the junior physician.

Pioneering in PLASMA SERVICE

Administrative angles on establishing and managing a successful plasma center

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SUPERVISOR, BLOOD PLASMA DIVISION
SOUTHERN BAPTIST HOSPITAL, NEW ORLEANS

TODAY, nearly a thousand hospitals in the United States are preparing human plasma or serum. Yet less than three years ago one could find hardly a dozen institutions doing such work.

The terms "plasma" and "serum" are not synonymous, although they are often so used. Plasma is made from blood to which has been added an anticoagulant, while serum is made by allowing blood to clot and then removing the liquid fraction.

Groundwork on the plasma service at Southern Baptist Hospital, New Orleans, was begun in November 1940 and we at once faced numerous problems. These, however, tended to group themselves into three main phases: administrative, medical and engineering. Since these problems were all closely interrelated we attacked them more or less simultaneously.

The first step was to sign up a list of prospective blood donors. This was done by Dr. Thomas B. Sellers of the hospital staff, who enrolled 40 men among the employes of a local oil refinery and 20 students from the Baptist Bible Institute in New Orleans. All of these people volunteered and when actual operations were begun they were bled in groups of from five to eight daily until all had donated. This provided a nucleus of plasma with which to start the service.

In the interests of safety we believed that all plasma processing should focus in a separate room rather than in existing laboratories. However, to facilitate administration and to avoid duplication of personnel, it was decided to incorporate the new service as a division of the department of pathology until such a time as it might achieve more or less independent status.

The only room in the entire hospital available for the new laboratory was a small coat chamber, 10 by 14 feet, connected with the doctors' lounge and adjacent to existing laboratories. This the staff voted to donate to the blood plasma division.

Thereupon, the engineering department of the hospital moved onto the scene and began fitting out the room with cabinets, work tables, gas, water and electric outlets and installed an electric vacuum pump, centrifuge and refrigerator. The last was a 12 cubic foot domestic model and has proved entirely satisfactory, although it has recently been supplemented with two large plasma bank machines, one providing for frozen storage.

The initial cost of setting up the laboratory was approximately $2000, including $360 for a centrifuge. Plasma may, of course, be prepared by simple sedimentation of the blood, but the yield from this is about 20 per cent less than from mechanical separation so that in the long run centrifugation is more economical.

Several months after we started making plasma the room was air conditioned, the machine costing about $500. While this may appear somewhat excessive it was actually not so since we were allowing for future expansion of the plasma laboratory. Air conditioning not only is desirable in promoting the comfort of people working in a closed room but is especially valuable in controlling dust and preventing airborne contaminations.

A cardinal policy of the plasma service was, and is, to receive blood only from volunteers, since the cost of professional donors would have to be passed on to recipients of the plasma. Since all of our donors are volunteers we are ethically and morally obligated not to sell the plasma made from their blood. However, it is only just that patients receiving plasma should, when able, bear at least part of the cost of processing. Ward and charity cases, on the other hand, are entirely exempt from any processing fee.

To encourage patients to send in donors and, at the same time, to build up the plasma bank the hospital gave credit for such blood by itself absorbing from half to two thirds of the processing cost. This practice continues in force and is

PLASMA SERVICE—BLOOD DONOR'S RECORD

SERIAL NO.	AMOUNT BLOOD	PLASMA YIELD	DISPOSITION OF PLASMA TO POOL NO.	ON

NAME _____ ADDRESS _____

OCCUPATION _____ TELEPHONE _____ AGE _____ SEX _____

MEDICAL HISTORY (INDICATE + OR O FOR POSITIVE OR NEGATIVE):

LUES _____ OTHER V. D. _____ MALARIA _____ TUBERCULOSIS _____

PNEUMONIA _____ BRONCHITIS _____ CORYZA _____ ALLERGY _____

RHEUMATIC D. _____ POLIO _____ SCARLET FEVER _____ OTHER DIS. _____

IMMUNIZATIONS _____ PRESENT HEALTH _____

PHYSICAL STATUS:

MOSS TYPE _____ WGT. _____ B. P. _____ / _____ PULSE _____ TEMP. _____ RESP. _____

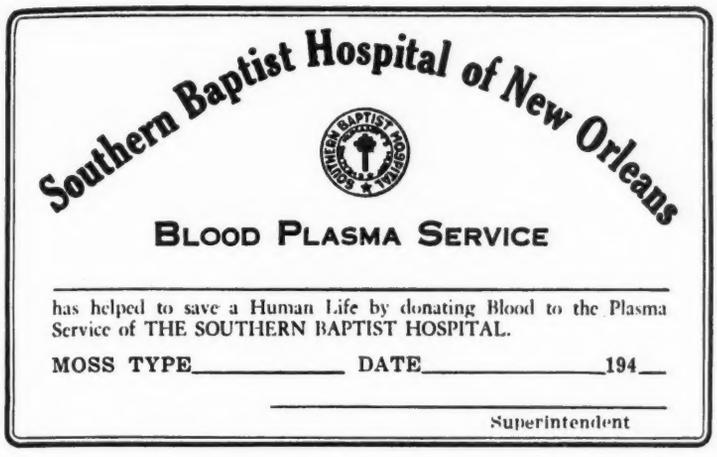
LYMPHATIC _____ E. E. N. T. _____ C. R. _____ OTHER _____

HEMOGLOBIN _____ WASSERMANN _____ KAHN _____ KLINE _____

I HEREBY CERTIFY THAT THE ABOVE-NAMED DONOR APPEARS TO BE FREE OF DISEASES TRANSMISSIBLE BY BLOOD TRANSFUSION ON THIS DATE, WHICH IS ALSO THE DAY OF REMOVING BLOOD FROM THE DONOR.

DATE _____ _____ M. D.
EXAMINING PHYSICIAN

2M .11-41 O'D SOUTHERN BAPTIST HOSPITAL OF NEW ORLEANS



Southern Baptist Hospital of New Orleans

BLOOD PLASMA SERVICE

has helped to save a Human Life by donating Blood to the Plasma Service of THE SOUTHERN BAPTIST HOSPITAL.

MOSS TYPE_____ DATE_____ 194__

Superintendent

PLASMA SERVICE—POOL RECORD

SERIAL NO.	POOL BEGUN	COMPLETED	TOTAL VOLUME	RELEASED FOR USE ON

SOURCES (Give Donor Serial Nos. and Individual Plasma Volumes)

DONOR	SERIAL NO.	VOL.	DONOR	SERIAL NO.	VOL.	DONOR	SERIAL NO.	VOL.

PROCESSING DATA:

CULTURE I TAKEN____ MEDIA____ READ____ RESULT____

MERTHIOLATE ADDED____ QUANTITY____

FILTRATION____ FILTER NO.____ TIME REQ.____

CULTURE II TAKEN____ MEDIA____ READ____ RESULT____

ANIMAL INOCULATION____ ANIMALS____ RESULTS____

FINAL CONTAINERS FILLED____

CULTURE III TAKEN____ MEDIA____ READ____ RESULT____

500 11-41 O'D SOUTHERN BAPTIST HOSPITAL OF NEW ORLEANS

extended to all patients in or near New Orleans regardless of what hospital they may be in.

It costs approximately $15 to prepare one unit (250 cc.) of plasma and administer it to the individual patient. In the beginning the figure was nearer $25 but experience has resulted in a streamlining of methods, with consequent reduction in operating costs.

We were confronted with a whole family of problems in choosing a technical procedure for making plasma. Should we operate both a blood bank and a plasma bank? This we decided against, since we felt, first, that an adequate supply of pooled plasma would make blood storage unnecessary and, second, that it would be better to concentrate on making plasma from fresh blood and not as a by-product of outdated banked blood. The experience of more than two years has borne us out in this.

Another major problem was the choice of bottles for taking blood and preparing and dispensing plasma. On the one hand, we could purchase reusable bottles and undertake to clean and resterilize them ourselves, or we could buy commercially prepared (nonreusable) bottles. After considerable study we decided on the latter, since we were satisfied that they not only would be safer but ultimately would prove more economical.

For collecting blood and dispensing plasma we routinely employ vacuum containers. All rubber and metal parts are salvaged. For intermediate steps in processing we use heavy heat and chemical resistant glass flasks prepared by the plasma service.

There are three ways to store plasma: liquid, frozen and desiccated. Each has advantages and disadvantages. Storage in the liquid state offers the advantages of relatively cheap methods and instant availability for use. Under U. S. Public Health Service regulations, such plasma may be stored for one year at room temperature. Actually, the product has been kept for as long as two and a half years and then used with therapeutic benefit and without reaction.

It has been said that the greatest disadvantage of liquid plasma is the possibility of contamination. However, if the plasma is properly prepared, put into a sterile container with aseptic precautions and hermetically sealed it should remain sterile indefinitely and can become contaminated only if the bottle is improperly opened. We have processed about 300,000 cc. of plasma and all of it has been stored in the liquid state, some in the refrigerator and some at room temperatures, and there have been no contaminations. The reaction rate in the recipients averages less than 0.5 per cent.

Frozen plasma retains all or nearly all of its labile qualities, such as complement, prothrombin and antibodies. Aside from the fairly high cost of freezing machinery this is the ideal method of storage. Ordinary quick-freeze and ice cream cabinets have worked well for this purpose, but freezing by cold air blast seems to be more efficient.

Desiccated plasma is costly to prepare on any large scale. Most drying technics now in vogue employ desiccation by vacuum from the frozen state. When we started our work we felt that liquid and possibly frozen plasma would be entirely adequate for civilian practice. We have had no reason to change this view and know from experience that liquid plasma can be safely shipped considerable distances without the necessity of refrigeration, arriving at its destination ready for use.

Of the utmost importance in undertaking the preparation of plasma was the selection of methods to ensure the safety and purity of the final product.

We could find no better standards of safety than the requirements of the National Institute of Health for processing human plasma and have made conscientious effort to conform to them. Essentially, these standards are: careful selection of blood donors; serologic test for syphilis on each donor; collection of blood in same container (with sodium citrate) in which cells will later be separated; the maintenance of a completely closed processing system in all phases

of processing from collection of blood to the filling of final plasma containers; pooling of plasma, minimum of eight donors to a pool; adequate bacteriologic control; animal inoculation safety tests; hermetically sealed final containers; proper labels on containers, and the keeping of complete and accurate records.

Any institution that processes plasma should observe these principles fully, regardless of the type of apparatus or specific technic used, for they are basic to the preparation of consistently safe plasma.

Some of the technical details of operating a plasma service are worthy of mention because of their administrative aspects.

First of all, consider the blood donors. These people are volunteers and give freely of both blood and time. Hence, it is our duty and our privilege to treat them with courtesy and consideration. The "production-line" attitude should be avoided and the donors should be treated for what they are—individual human beings trying to help somebody. At our hospital refreshments are provided following bleeding and we have found "a pint of milk for a pint of blood" to be an excellent idea, both psychologically and physiologically.

Each blood donor is mailed a card bearing his name and blood type. Many favorable comments have been received on these, although they are not original with us, having been adapted from cards issued by the Blood Donor Honor Roll of the New Orleans police department.

Saves on Rubber Gloves

In collecting blood we have developed a procedure that obviates the use of rubber gloves. This has been followed for a year with uniformly good results and a considerable saving in wear and tear on gloves. It is worthy of mention also that we get maximum life from rubber tubing by storing it in the air conditioned plasma room in light-tight boxes and also by piecing together once discarded short lengths with glass connectors.

All plasma made here is routinely Berkefeld filtered, a procedure used in an extremely small number of laboratories and a major item in processing costs. The filters are made of fine clay or infusorial earth and, in addition to their chief function of removing any bacteria present, they extract nearly all of the lipoids in "fatty" plasma. The latter result, while entirely secondary, serves a useful purpose because we have found that in receiving large numbers of blood donors, about 50 per cent disregard our instructions relative to a fat-free diet prior to bleeding. "Fatty" plasma has some tendency to cause urticarial reactions (hives) in recipients.

Why the necessity of this filtration when the blood is collected and plasma is separated under strict aseptic precautions? The answer is this: even with the best of technic one may pick up bacteria from the donor's skin and even healthy people sometimes have bacteria floating around in their blood streams. Hence, these organisms may be collected with the blood and, although they usually do not survive refrigeration and the presence of preservatives in the blood or plasma (and thus fail to grow in culture media), they still remain as dead bodies capable of causing pyrogenic reactions.

In December 1941 the small centrifuge was replaced after making 30,000 cc. of plasma. It had replaced a worn-out machine in the serology laboratory and was itself supplanted by a six-place windshielded centrifuge of superior power and speed. While installation of this new equipment cost about $1500 it has nearly paid for itself because of its greater efficiency. In addition, a saving is being made in blood bottles. With the old machine two 300 cc. bottles were required for each donor. These cost $1.35 as contrasted to 75 cents for one 600 cc. vacuum container.

Because of its tendency to form fibrin deposits or clots on standing, (especially in the refrigerator), all plasma must be filtered during administration. Routinely employed for this purpose are the stainless steel filter drips commonly used for citrated whole blood transfusions. Some time ago a death was reported in Detroit from the use of unfiltered plasma because fibrin particles entered the patient's blood stream and caused fatal emboli. Every bottle of plasma should carry a warning label concerning the necessity of filtration. Also, whenever we send plasma to another hospital a warning sheet is enclosed.

Adequate records are essential to the smooth functioning of any organization and a plasma service is no exception. Records should be thorough but brief. At first we experimented with mimeographed forms, so changes could be inexpensively made. Finally, printed forms were evolved which allow us to keep a close check on the entire procedure.

The blood plasma service was organized with two aims in mind. One was to make it a central cooperative affair like the Dade County Blood Bank at Miami. The other was, and is, to undertake the preparation of various immune convalescent serums.

By means of a mobile blood collecting unit, established in January 1942, plasma is being supplied on a cooperative basis to 12 communities within 150 miles of New Orleans.

Four Projects Given Federal Aid

Every day brings the war a little closer home. On May 29 the Southern Baptist Hospital became the eighth institution in the country to receive a grant from the U. S. Public Health Service to aid in setting up a special plasma reserve for the Office of Civilian Defense. Donors to the O.C.D. plasma bank are mailed a special card. Three other hospitals in New Orleans have also received federal grants for plasma projects.

The phase of plasma work that is of lowliest estate is, paradoxically, of highest importance. I refer to the "dishwashing job," as laboratory folks call it, the cleaning and sterilization of equipment. The importance of doing this thoroughly cannot be minimized. From three to four hours are spent on this work for every one devoted to the actual production of plasma.

There is no short cut, no easy method of making plasma. The best results can be obtained only by careful selection of donors, aseptic technic, a completely closed system and, above all, scrupulous care in cleaning and sterilizing equipment.

I wish to acknowledge the generous cooperation and friendly encouragement of the following persons who have helped to make the blood plasma service possible: Dr. Charles Drew, Washington, D. C.; Dr. Maurice Hardgrove, Milwaukee; Lt. Col. Douglas B. Kendrick, M.C.; Comdr. Lloyd R. Newhouser, M.C.; Dr. Sidney Levinson, Chicago, and Dr. M. V. Veldee, Bethesda, Md.

ST. MARY'S HOSPITAL DULUTH, MINN.

SISTER M. PATRICIA
ADMINISTRATOR

Results of a program of remodeling and renovation included nine new laboratories, modernized patients' rooms, attractive dining room and modern stockrooms

Top: The chemistry laboratory, one of the nine new units created at St. Mary's Hospital by the renovation of a section of the east wing. The remodeling enables the hospital to have separate departments for pathology, hematology, bacteriology, chemistry, blood typing and histology. Fluorescent lighting, glass brick walls and the latest types of cabinet work were installed in each unit.

Center: A new guest dining room was obtained by converting space formerly used as a canned goods storeroom. This space was made into a banquet hall that can be divided into two private dining rooms by a screen of three knotty pine Colonial cupboards. The walls are decorated with washable wall covering in a soft red. The background of the draperies is turquoise. New Colonial windows and woodwork were installed and the ceiling was suspended to cover steam pipes. The chandeliers are of crystal.

Bottom: The remodeling job included the modernization of 12 patients' rooms, which were brought up to date with new furnishings. This room is an example of the Swedish Modern design, one of the two types of furniture selected. Others were decorated in the Dolly Madison period. Sixty new floor lamps of special design, featuring a night lamp, were also purchased for use in the patients' rooms.

It's Up to the Occupational Therapist

To keep tuberculous patients from leaving "against advice"

STELLA RANDOLPH
HEALTH DEPARTMENT, DISTRICT OF COLUMBIA

THE problem of tuberculous patients who leave sanatoriums and hospitals "against advice" is one of the most pressing of public health control. This is not merely a problem of delayed recovery or, perhaps, fatal results so far as the patient himself is concerned; it means increased hazard to his contacts outside the sanatorium and the greater problem for the health authorities of preventing the spread of tuberculosis.

How shall such patients, many of whom are of such educational and mental status that they cannot always be made to comprehend these dangers, be induced to remain in the sanatorium through the long slow process of recovery?

It may suffice for a time that doctors and nurses, and even the patient's family, explain to him his need for quiet, peace of mind and cooperation with the profession in order that cure can be effected. They may and usually do help to control the patient's eagerness to be returned to his home life, but it is necessary to arouse the patient's interest in something progressively stimulating and tangible so that he will find it more profitable to remain in the sanatorium. He must be able to look out upon the opening day as one of promise rather than as just another of the 365 or more that he knows confront him in dreary procession.

This dull outlook affords too much time for retrospect, introspect and worry about financial problems or more minor things, such as why the breakfast eggs today were cooked for four minutes rather than three. Physicians know from experience the danger that lies in allowing the patient to devote himself to an orgy of mental depression. But the doctors are busy with the physical needs of the patient, as they should be, and what mental uplift they can offer him is, after all, rather fleeting and temporary.

Members of the family may have considerable insight into this problem, but even if they knew the solution their time with the patient is, of necessity, limited.

While the cooperation of the entire sanatorium staff is essential to keep the patient on the road to recovery and to help him find satisfaction with his progress, and while it is undoubtedly true that some well-founded courses in applied psychology may be useful to the entire staff to this end, in the last analysis it must devolve upon some one branch of the staff to devote itself to the problem of holding the patient in the sanatorium for a sufficient length of time. Officials are generally reluctant to resort to legal measures for this purpose. Far better results can be obtained when the patient, no longer restive, voluntarily elects to remain under the care offered by the public service.

Unless the patient can be kept in the sanatorium, all other services available to him are obviously of no value. The problem is squarely up to the occupational therapist. It is definitely a challenge, this matter of finding ways of keeping the patients sufficiently interested and occupied, both mentally and physically (yet not beyond their physical strength), to keep them happy. All the resourcefulness of a resourceful profession is called upon—a profession that indeed appears, upon review of its history, to owe its professional status mainly to imagination, research and the development of its concepts and methods of service.

The answer lies not in merely furnishing the patient light amusement for idle hours, as was the first conception of the occupational therapist's job. The occupational therapist must now, if she is to meet the requirements of the situation, be psychologist, friend, teacher, something of a practical nurse and, in addition, a salesman, selling her ideas alike to the patient and his prospective employer upon his discharge from the sanatorium.

That these qualities are expected and taken more or less for granted in the modern occupational therapist is eloquent expression of the extent to which this profession has developed.

In 1902, Dr. Herbert J. Hall became an ardent enthusiast for occupational therapy and did much to start an active movement, which finally resulted in the official establishment of a federal rehabilitation program on June 2, 1920. Prior to this time six states had recognized the value of this service and had set up their own programs. Since then, both the Social Security Act (Aug. 14, 1935) and amendments to this act on Aug. 10, 1939, have enlarged the scope of the program. Occupational therapy had demonstrated its value. Today, no state need be without rehabilitation service because of lack of funds.

The lack of well-qualified, enthusiastic and able occupational therapists is more likely to present a problem. With 40,000 tuberculosis sufferers in this country in need of vocational rehabilitation and able to profit by it, the occupational therapists have before them a job of great magnitude and difficulty.

The mere ability to teach handicraft is not enough. Indeed, teaching is only a small part of the work. An honest interest in each individual and a knowledge of his personality come first. It is essential for the occupational therapist to know what the varying moods of her patients indicate. Is this patient sullen and morose today because of physical suffering or is he worrying about some personal problem? The occupational therapist will get nowhere in par-

ticular with her teaching or with her job of retaining the patient in the sanatorium in a status in which he will profit most from what it offers until she has the answer.

Is that patient indifferent today to the work he was so eagerly engaged in yesterday? Why? The occupational therapist must find the answer by whatever means she can so long as she does not permit the patient to sense by any slightest attitude on her part that she is disturbed about him. Otherwise, she may find him offering her a variety of attitudes merely for the sake of gaining attention and mental diversion in a way that will have her at her wit's end.

In short, it is not enough that the sanatorium has engaged an occupational therapist to work with the patients. Nor is it enough that she is highly trained and skilled in the latest methods. What does matter is that such an employe be keen enough to note and understand the moods and reactions of the patients and be wise in finding ways to meet them.

In many cases the financial problem looms large and dark on the horizon, keeping the patient disturbed and panicky at a time when peace of mind and rest are most important. It is wise, therefore, to begin at once to discover the particular financial problems of the patient, his aptitudes and potential ability for employment, and to begin slowly and painstakingly to work toward this goal. The encouragement and mental uplift of such a beginning are invaluable.

The road to rehabilitation for the tuberculous patient is particularly long and winding, covered at first not inch by inch but, if he is fortunate, quarter inch by quarter inch. Whatever occupation he undertakes must naturally be limited by the advice of his physician, and it is here that the occupational therapist must exercise judgment, noting quickly signs of fatigue or other conditions that call for a cessation of activity before the patient is anywhere near the point of exhaustion.

The mental capacity of her patient plus the ultimate acceptability and usefulness of the occupation for which she plans to train him is the all-important and essential knowledge for the occupational therapist in these early days. The disheartenment of discharge to the community, prepared for some specific employment for which there is no opening, has a physical and mental reaction that may soon return the patient to the sanatorium.

It is equally important later that the patient about to be discharged will be helped to obtain employment. Employers will object either that the patient will not be able to carry his economic share of the load or that others will not want to work beside him, while the public, when it knows tuberculous patients are handling the products, will be frightened away.

These are problems of salesmanship for the occupational therapist, at least in part. The health education expert may assist in creating an understanding of the lack of danger to the public under the specific conditions existing. On the other hand, it may help if the patient can be trained for a time in some place that is not known as a school for the rehabilitation of the tuberculous so that he will not be labeled by his place of training.

All of these problems together are not so difficult for the occupational therapist as are the long hard pull of day to day control of the patient and his moods and the skill required to develop his mental and physical abilities. No routines she has learned can meet the need. The full range of old and new teaching methods must be drawn upon, skills and psychology must both be brought to bear upon the subject, to which must be added a pleasant and cheerful personality and, particularly, imagination coupled with sincere interest in understanding of each individual patient.

It is exhausting and exacting work. For those who want employment that lacks monotony and routine, employment that is rich in rewards of satisfaction, such as result from having aided others to a better way of life, and for those who can let others lean heavily upon them on the upgrade, the position of occupational therapist in the tuberculosis sanatorium is eagerly waiting. And not until the tuberculosis sanatorium can acquire personnel of this type will it succeed in keeping patients from "leaving against advice."

This Is No Time for Pessimism

AT THE recent A.H.A. convention in St. Louis Everett Jones, head hospital consultant, Governmental Division of the W.P.B., stated in effect that "things will be so much tougher a year from now that you will look back at the present and think it was a picnic."

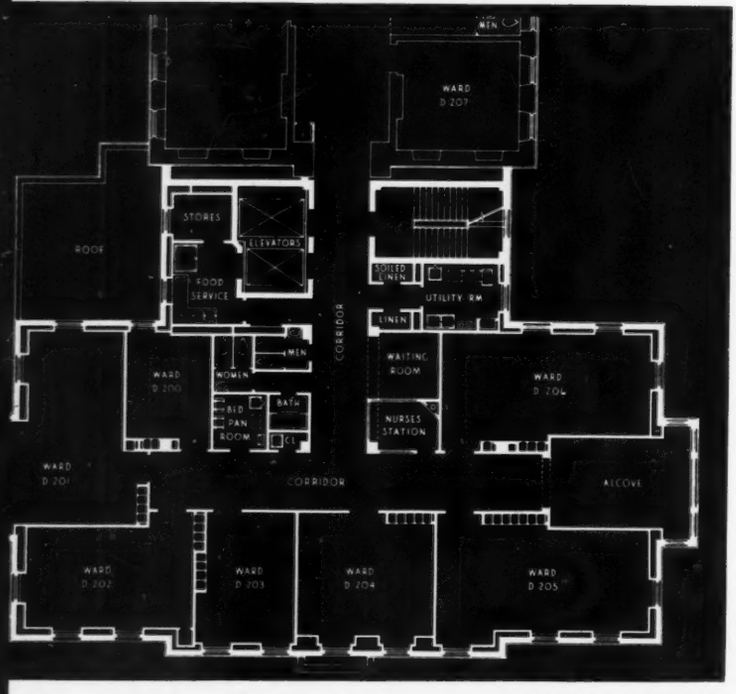
I wonder if we do not owe it to ourselves to do what we can to mitigate this rather fatalistic view, which has the effect of discouraging some steps that might be taken to make things a little less tough than they would otherwise be. It sounds a great deal like telling a sick man that there is no use having a shave today because he will probably be dead tomorrow! Possibly the moral stimulus of having a shave today might give him just enough more ginger to survive his crisis.

Some of us have been accused of treason for daring to criticize the methods used for syphoning doctors into the Army in the last nine or ten months, and only in the past few weeks has the country, and particularly Congress, waked up to the fact that this type of recruiting has been grossly overdone and that the vital interest of many millions of workers in war industries has been overlooked.

No doubt, the A.H.A. is doing what it can to soften the blows that are falling upon us, but I for one do not subscribe to the theory that because things are going to be worse next year we should relax our efforts in the direction of improving present conditions and preventing needless interference with hospital operation.

When the public wakes up to find that it is not being adequately served it may fail to class as a virtue our placid acceptance of the conditions that may have crippled us. If we go down fighting we shall deserve much better of our communities than if we surrender without a fight.—F. STANLEY HOWE, *administrator, Orange Memorial Hospital, Orange, N. J.*

SECOND FLOOR PLAN



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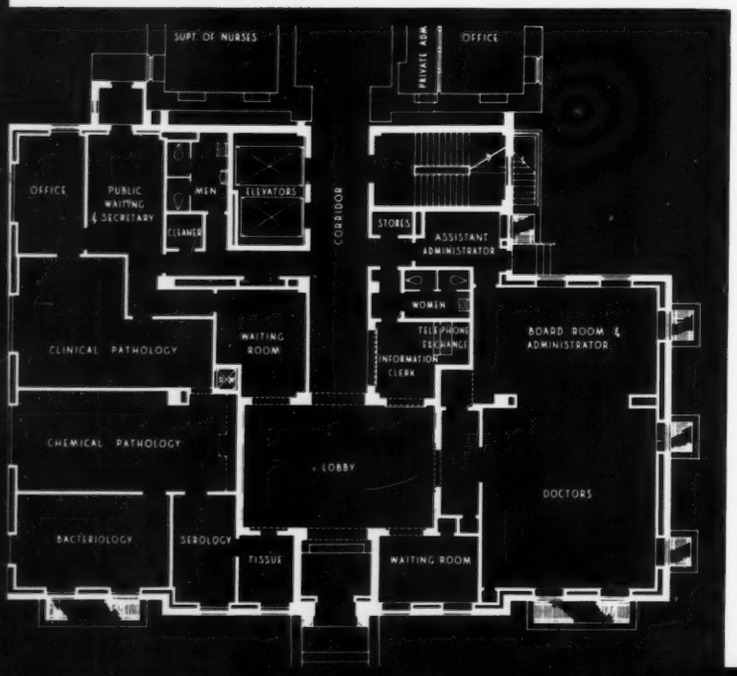

JOHN THOMPSON DORRANCE MEMORIAL
COOPER HOSPITAL, CAMDEN, N.J.

LEROI A. AYER
SUPERINTENDENT

ARTHUR H. BROCKIE
ARCHITECT

WILLIAM E. GRANCELL
ASSOCIATE ARCHITECT

OUTLINE OF CONSTRUCTION DETAILS

GENERAL DATA: General unit of Cooper Hospital, Camden, N. J., donated by the Campbell Soup Company in memory of John Thompson Dorrance. 80 beds, 6 bassinets. Building construction started September 1940; completed October 1941.

CONSTRUCTION: Reenforced concrete, fireproof construction throughout. Exterior walls, 8 inch brick faced with gray smooth brick. Main entrance feature, limestone. Trim and cornices, terra cotta. Interior walls, terra cotta tile and gypsum block. Wall furrings and all ceilings, metal channels and metal lath. Walls and ceilings finished with hard plaster.

STAIRWAY: Reenforced concrete, enclosed with brick walls.

ELEVATOR SHAFT: Brick with hollow steel doors and frames.

DOORS: Flush veneered selected white maple. Natural finish. Hung to steel frames finished flush with plaster.

WALLS: Food service department, operating rooms, baths, toilets and bedpan, sterilizing and utility rooms, tile wainscoting.

FLOORS: Wards, private rooms and corridors, linoleum with rubber base. Operating rooms, anesthesia rooms and recovery rooms, terrazzo with grounded antistatic grids.

EQUIPMENT: Cabinets in nurses' workrooms, food service rooms and nurses' stations, solid steel construction with porcelain enamel face and stainless steel work top. Utility rooms, sterilizing units, warming cabinets, work sink, hopper and gas hot plate.

COSTS: Not including architects' and engineers' fees, $293,764.09. Total cubage, 473,124 feet. Cost per cubic foot, 62½ cents. Cost per bed, $3415.

CHILDREN'S WARD

Save Fuel and Have Heat

Hospitals in rationed areas can save 10,000,000 gallons of fuel oil by following the measures outlined in this article, the authors predict

OIL is a convenient fuel. It is clean and inexpensive. Because it can be automatically controlled, its use reduces boiler room manpower to the minimum.

Oil, however, is no longer plentiful along the East Coast and in the Midwest. Shortages appeared in the spring of 1942 as the war disrupted normal oil transportation facilities. The Office of Price Administration was therefore directed to ration fuel oil this winter. Its program went into effect October 1.

Since then, the opening of the African campaign has placed even greater demands upon fuel oil supplies available to the eastern half of the United States. The original rationing program can no longer assure adequate amounts of oil for all essential users unless further cuts in outstanding rations are made wherever possible and the essential users voluntarily eliminate all waste in their consumption of oil.

Hundreds of hospitals use oil for heat, hot water and power. Hospitals are essential users; their supplies cannot be drastically curtailed. But hospital administrators and chief engineers can be sure that they are not wasting oil. Under current conditions, oil waste is inexcusable.

Recently, the Bureau of Governmental Requirements of the War Production Board and John G. Neukom, chief of fuel oil rationing branch of O.P.A., requested a group of hospital chief engineers to meet and prepare an informative article describing the principal ways in which hospitals can reduce fuel consumption to a minimum. This article is the result.

1. Comparison of CO_2 in Flue Gas With Preventable Fuel Loss*

% CO_2	*% Preventable Fuel Loss*
14.0	0.00
13.0	1.03
12.0	2.22
11.0	3.63
10.0	5.33
9.0	7.39
8.0	9.97
7.0	13.30
6.0	17.72
5.0	23.94
4.0	33.23
3.0	48.80
2.0	79.90
1.0	No Steam

*Based on 500°F. flue gas temperature.

2. Loss Resulting From Stack Temperature*

Flue Gas Temp. °F.	*Total Stack Loss*
300	12%
400	14%
500	16%
600	18%
700	20%
800	22%

*This is based on 13 per cent CO_2.

BOILER ROOM EFFICIENCY

1. **Instruments:** Instruments that record CO_2 per cent, stack temperature and steam pressures provide a continuous record of combustion and operating conditions. Such instruments should be used and kept in proper working order. Even when used steadily and maintained properly, it is advisable to check them periodically by means of hand-operated gas analysis apparatus and stack thermometers.

If continuous recording instruments are not used now, they should be installed, if available. If it is necessary to operate without them, apparatus for gas analysis and stack thermometers should be obtained and used for testing combustion conditions at least every few days.

2. **Efficient Combustion Conditions:** The per cent of CO_2 in the combustion gases is a measure of combustion efficiency. Readings of less than 10 per cent are considered poor. Readings in excess of 14 per cent are considered impractical.

Stack temperature tells whether or not the maximum amount of the heat generated in the combustion chamber is transferred to the water sides of the boiler or is wasted up the stack. Temperatures ranging from 350 to 600° F. are considered satisfactory under normal operating conditions. A temperature lower than 350° F. brings on troubles resulting from a cold stack; a temperature higher than 600° F. indicates waste up the chimney.

3. **Controls:** These are sensitive instruments. Dirt and wear reduce their sensitivity and lead to waste of fuel. All controls should be cleaned, adjusted and repaired periodically.

4. **Boiler Maintenance:** Boilers must be tight and clean if they are to do their work efficiently. If they are not tight, excess air will leak into the combustion chamber where it will cool the oil flame and prevent complete combustion. Air leaks are commonest around fire and clean-out doors and around the base. A lighted candle held close to the boiler while it is operating and

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moved slowly around will disclose leaks, for the air being sucked in will draw the candle flame with it. All leaks should be filled with furnace cement.

Soot on the flue gas sides of boiler heat transfer surfaces and scale and rust on the water sides should be removed periodically. A one eighth inch coating of soot reduces boiler efficiency approximately 10 per cent. Scale and rust are equally effective in lowering the work capacity of a boiler.

Any boiler not now insulated should be covered at once. Old boiler covering should be inspected and replaced if broken or cracked.

5. **Boiler Operation:** Feed water entering the boiler should be preheated either by exhaust steam or electrically, wherever practical. By piping vapor discharge from sterilizer and kitchen returns to a flash tank, the vapor can be used to increase feed water temperature or to aid in heating the hot water supply. The resultant saving in oil is about one half gallon per hour for every 50° F. rise in feed water temperature.

Boiler doors should not be left open unnecessarily.

Steam flow should be adjusted with changes in outdoor temperatures.

6. **Draft:** The need for damper and draft regulation should be investigated. Improper regulation is a major reason for improper air supply with resulting inefficient use of fuel.

7. **Piping and Valves:** Uncovered steam pipes waste heat. All pipes should be covered, especially at joints, and all old covering should be inspected for breaks and cracks.

Valve packings should be tight.

All steam traps that are used twenty-four hours a day should be kept in repair.

If a room or a wing is hard to heat, the rest of the building should not be overheated to bring the underheated part up to temperature. A heating engineer should be employed to go over radiation and piping in the hard-to-heat area and his suggestions should be followed.

8. **General:** If the hospital generates its own power from oil, the possibility of using utility power produced from coal should be investigated.

An exchange of boiler room operating ideas between hospital and other plant engineers would be especially helpful and patriotic now.

All heating equipment should be checked for defects; the burner must be properly adjusted and combustion chamber walls should be kept in good condition.

It is advisable to stagger the oncoming loads in the morning so that the loss of warm condensate is reduced to the minimum. In some hospitals the kitchen load comes on at 5 a.m., the heating load at 6 a.m., the laundry load at 6:30 a.m. and the instrument sterilizer load at 7:30 or 8 a.m. This is a good schedule.

The cooling cycles of air conditioning systems should not be used.

HEAT LOSS REDUCTION

1. All radiators in lobbies and halls that are not required for reasonable and necessary temperatures should be turned off and the handles should be removed to prevent tampering.

2. Nurses' quarters and those of other personnel should be heated according to ration regulations. Such quarters are entitled only to two thirds as much fuel as they would require in a year of normal degree days.

3. All nurses, interns, doctors and patients should be instructed in the proper way to cool an overheated room. The proper way is to turn off the radiator. Opening a window to cool a room is not necessary except on rare occasions, and on those occasions the radiator should be turned off while the window is open. Under no circumstances should a radiator be on while a window is open.

4. All maintenance areas, *i.e.* laundries, shops, offices, should not be heated at night.

5. If outside window and door frames have not been calked, this should be done at once. A gun and calking compound are inexpensive and any handy man can learn to calk in a few minutes.

6. All loose-fitting window sash should be weatherstripped with felt and wood strips.

7. Storm windows should be installed on all exposed sides.

8. Shades or venetian blinds in all unoccupied rooms should be drawn night and day. At night, windows in all maintenance and office areas and, wherever possible, in patients' rooms should be similarly covered.

9. All outside doors used by visitors should be double, whether standard or revolving.

EQUIPMENT MANAGEMENT

1. The great majority of hospitals waste tremendous quantities of hot water. Proper management and personnel instruction can reduce this.

2. The temperature of domestic hot water should be 140° F. For uses requiring higher water temperatures, a booster should be used instead of heating all water to the higher temperature.

3. Stickers reminding personnel and patients of the need to use hot water sparingly should be placed near each faucet.

4. The number of hot rinses in the laundry should be reduced to the absolute minimum. All the laundry work should be done at one time and the laundry should then be shut down for the day.

5. Insofar as possible dish washing should be restricted to certain times of the day in order to reduce hot water consumption.

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POSTOPERATIVE
Management of Medical Problems

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DURING the first twenty-four hours after surgical intervention for gastric and duodenal disorders nothing is given by mouth. An infant who has been operated upon for pyloric stenosis may, however, be given water by mouth eight hours after operation. If this is retained, increasing amounts are offered at hourly intervals and breast milk or formula can be offered at the end of twenty-four hours. Otherwise, parenteral administration of dextrose and saline maintains the child comfortably until he is able to take and retain food by mouth.

The stomach has a rich blood supply and so heals quickly in children. A good plan is to give hypodermoclysis of saline and intravenous injections of 5 per cent dextrose fulfilling the fluid requirement for the first twenty-four hours. On the second day, 15 cc. of 5 per cent dextrose is given every hour; on the third day, 30 cc. every hour, on the fourth day, the hourly fluid is alternated by an equal volume of fruit juice. The total daily fluid requirement is fulfilled by parenteral dextrose and saline. By the fifth day, liquid diet is offered and by the eighth day, a soft diet.

Food additions are made gradually by the "staircase" method according to individual tolerance. A small amount retained is much better for body economy than a larger amount vomited. If the feeding has been advanced too rapidly it is advisable to recede a day or two in the schedule.

Pyloric Stenosis. Postoperative care is an important transition toward complete recovery. Some of the measures used preoperatively may have to be continued if the symptoms persist. The feeding is given cautiously, the amounts being gradually increased until the infant receives the required breast or artificial feedings by the end of the first or second week after operation. Water is likewise given in small quantities, alternated in increasing amounts with milk feedings. If vomiting does occur it may be relieved by decreasing the amount of food given, elevating the head and shoulders to enable the infant to release gas and introducing a stomach tube before feeding if necessary.

The fluid requirement can rarely be fulfilled by oral administration alone; hence, parenteral fluid should be injected twice daily. At the end of a week the nursing infant may be put back to the breast, allowed to nurse for from two to three minutes and the nursing time gradually increased. In most cases the infant begins to thrive a few days after operation and remains free from digestive disturbances.

Bile and Liver Disorders. The marked tendency to rapid depletion of glycogen reserve in the liver calls for parenteral dextrose and high carbohydrate regimen. Parenteral dextrose solutions must be given daily until easily assimilable carbohydrate is well borne by mouth. The bleeding tendency during the first week may be overcome by parenteral vitamin K administration to make up prothrombin deficiency in the liver. Often the first internal bleeding is bloodstained bile from the drainage tube. The loss of fluids, sodium chloride and bile salts with drainage may be compensated by parenteral administration of sodium chloride and dextrose and bile salts by duodenal tube. Despite the loss of calcium salt, there is no need for replacement therapy because of the normal feeding rapidly instituted. With the clearing of the nausea or vomiting the liquid diet is gradually shifted to soft diet preponderant in carbohydrates throughout the convalescent period.

Acute Appendicitis. The initial concern is to give adequate rest to the inflamed area. This is achieved during the first twenty-four hours by withholding all food and offering sedatives, such as morphine whenever required—1/16 grain for a child of 3, 1/12 grain for a child of 6 and 1/8 grain for a child of 9. Obviously, no purgative should be given at any time. If there is any abdominal discomfort and distention, an enema containing sodium bicarbonate, milk and molasses or turpentine with oil of peppermint may be given, but not until the third day after operation.

Fluids, such as water alone or reenforced with dextrose or flavored with fruit juices, are offered as soon as possible after recovery from the anesthetic. They should be offered by mouth at room temperature, for iced drinks increase peristaltic activity. The amount offered should be increased gradually, according to tolerance to prevent dehydration. The hygienic condition of the mouth should be carefully maintained by rinsing with cold water or mouth washes. The amount of fluid taken may also be increased by offering lollipops, fruit drops, peppermints or

other sugar that produces no residue on swallowing.

Additional fluid requirement may be fulfilled in younger children by hypodermoclysis of 5 per cent dextrose normal saline, twice a day if necessary. Older children may be given additional fluid by rectum, administered by either continuous drip or interrupted infusion method. Plain water, 5 per cent dextrose or normal saline is given at four hour intervals in from 4 to 6 ounce amounts. It is introduced at body temperature, at a slow rate and in small quantities at a time to ensure retention without causing colonic irritation.

On the second day after operation, the child may be given a liquid diet consisting of weak tea, skimmed milk, broths, strained fruit juice. On the third day, thin cereal, gruels, gelatin and custards may be added. Other foods are gradually introduced until the diet becomes adequate for the child by the first week after operation.

Diabetes. The diabetic child fares best postoperatively if returned to the accustomed diet and insulin regimen. Urinary sugar and diacetic acid tested at three hour intervals, as well as the total sugar content in the twenty-four hour specimen, enable the determination of insulin dosage. Indeed, insulin may be given at three hour intervals according to the sugar excreted, the metabolic status of the child being helped rather than aggravated. As a rule, 15 units are necessary for red, brown or orange colored urine, 10 units for yellow, five units for green and none for the blue Benedict tests. Parenteral saline should be given according to individual needs. Intravenous dextrose should be injected only in children who are unable to take sufficient carbohydrate by mouth. Excessive carbohydrate induces glycosuria and, hence, exacts greater insulin dosage. Most patients are able to consume so little dietary protein and fat after operation that fluids and carbohydrates remain the only dietary components. Actually, the child may eat what he can, provided the total twenty-four hour carbohydrate intake is covered by adequate insulin dosage. If the child is unable to take any food by mouth, acidosis is imminent unless dextrose is given intravenously. Blood sugar determinations are necessary even when the urine remains free from sugar and there is danger of hypoglycemia when the urine is charged with diacetic acid. Insulin dosage must be readjusted after convalescence.

Nephritis. Adequate urinary output in renal patients during the first few days after operation is important. Most of the fluid requirement is given parenterally in sufficient volumes to ensure an adequate daily output of 1000 cc. It is best given in the form of 5 per cent dextrose solution, unless fluids are lost by vomiting or diarrhea when normal saline is given in addition. It is to be remembered that excessive saline solution leads to fluid retention and edema. Diuretics are undesirable. In the presence of acidosis revealed by a decrease in the CO_2 combining power of the blood, calculated amounts of sodium bicarbonate may be given by mouth or by intravenous injection but never by hypodermoclysis.

Burns. The immediate treatment of severe superficial burns is in the control of shock. This consists of maintaining body temperature, administering fluids parenterally and giving necessary stimulants. Once the symptoms of shock have been completely abolished, the surgical treatment of burns may be instituted. The real difficulty lies in the management of toxemia after shock has been cleared.

The factors determining the development of toxemia are dehydration, combated by continuous venoclysis until a generous flow of urine is induced, and bacterial infection treated locally. Blood transfusions combined with adequate treatment of dehydration contribute greatly to recovery. The diet is determined by the pathologic physiology in the individual case, instituted as the child recovers from shock and toxemia. The liquid diet is displaced by more essential nutrients when the child's condition warrants the change.

Total calorie intake should be increased as soon as is feasible because of the increased body metabolism during fever. Adequate protein is provided to maintain nitrogen balance, assimilable carbohydrate is increased for quick energy but fat intake is kept low unless tolerated. The mineral intake is high, particularly in iron to combat anemia and in sulphur to enhance epithelial growth. The vitamin content is optimal to favor nutrient utilization and tissue regeneration.

How to Feed a Patient

ONE speaks of feeding a patient as if it were a perfectly simple and straightforward operation that is always carried out in one way, whereas, in fact, there are almost as many variations as there are patients and nurses. These reflections are expressed by a patient in "Cogitations in Bed," published in the August 1942 issue of *Hospital and Nursing Home Management.*

The success of the operation, like a good many other things, depends upon the extent of cooperation between feeder and fed.

For example, a patient who cannot see is reluctant to allow anything that he doesn't know all about to proceed down his throat. A considerable amount of persuasion may even be necessary to induce him to open his mouth. On the other hand, the nurse may put something into it on the end of a spoon that is normally found on a fork. Then, too, she may drop it in or she may almost throw it in.

There are other variations that result from the patient's customary use of condiments or his use of one vegetable with another or both with a piece of meat. Every patient has not only his own particular fancies but also well-established eating habits of which the nurse knows nothing. Therefore, the patient has almost as much to impart to her as she has to him.

Nevertheless, like a great many other procedures in a hospital, the feeding of a patient can be quite entertaining if both parties are able to regard it in the spirit of a good game.

SMALL HOSPITAL FORUM

Reporting to the Community

Why issue an annual report?
To whom should it be sent?
What should it contain?

GREAT variation in ideas regarding hospital annual reports is evident in the replies sent by the 19 hospitals listed in response to an inquiry for the Small Hospital Forum. The hospitals chosen for inquiry this month are somewhat larger than those that usually contribute to the forum because it was believed that relatively few of the extremely small hospitals would issue reports.

Most of the hospitals also generously sent copies of their recent reports. These show even greater differences in concept, in appearance and in style than do the answers to the questions.

Thirteen of the 19 hospitals issue some kind of an annual report. The cost and number of copies varied from $3 for 20 typed copies to $408 for 2000 copies. Four hospitals spent less than $100; two spent from $100 to $200, and three spent more than $200. Most of those reporting distributed about 400 or 500 copies of their reports.

"Do you believe that hospitals of less than 100 beds ought to issue annual reports?" Thirteen replied "yes," including two administrators of hospitals that at present do not issue reports. Four said "no" and two said that the answer depends upon local conditions. The only reasons given for not issuing reports are lack of funds or a belief that a house magazine is better.

The following reasons for issuing a report were mentioned: the public has so little knowledge about a hospital and an annual report gives information in compact form; a report serves to stimulate the hospital to higher standards of achievement; donors, contributors and volunteers are entitled to know the facts about the hospital; it is good publicity; it helps to interest new friends in the hospital; it is an ethical way to review the year's work; it helps to inform the trustees; it offers a convenient list of the medical staff, trustees, administrative and nursing staffs; it dignifies the institution.

The type of material published in the annual report usually reflects the judgment of the administrator as to what is of general interest. One hospital has a report consisting solely of statistics on the various departments and the administrator rightly says that she thinks it would be of little interest to the general public.

Another hospital publishes a report that is attractively prepared and well designed but has no pictures and almost no text matter. It consists almost entirely of lists (trustees, medical staff, hospital staff, house officers and women's auxiliary), a financial report, a statistical report, information for prospective patients, a form of bequest and ways of helping the hospital. The only general statement is a brief foreword by the president of the board. While this report contains a great deal of information, it almost completely lacks any real appeal. For the same amount of money, a much more effective public relations tool could have been prepared.

It is questionable whether information for patients and information about the school of nursing ought to be included in an annual report. It would probably be less expensive and more effective if these sections of the report were printed separately in small leaflets.

The best written of the reports sent in for this study is the one published by Flint-Goodridge Hospital of Dillard University, New Orleans. This report opens with a brief quotation from Dr. Otho F. Ball: "A hospital may be a distinguished institution, no matter what its size. If it is great in spirit, original in its outlook, creative in its service and

CORRESPONDENTS

St. Luke's Hospital, Racine, Wis. (120 beds)
Providence Hospital, Mobile, Ala. (106 beds)
Ivinson Memorial Hospital, Laramie, Wyo. (80 beds)
St. Peter's Hospital, Helena, Mont. (63 beds)
Mount Desert Island Hospital, Bar Harbor, Me. (68 beds)
Cape Cod Hospital, Hyannis, Mass. (65 beds)
Oklahoma Baptist Hospital, Muskogee, Okla. (125 beds)
Bryan Memorial Hospital, Lincoln, Neb. (100 beds)
General Hospital, Syracuse, N. Y. (110 beds)
Exeter Hospital, Exeter, N. H. (73 beds)
Flint-Goodridge Hospital, New Orleans (100 beds)
William Booth Memorial Hospital, Covington, Ky. (94 beds)
Faulkner Hospital, Jamaica Plain, Mass. (175 beds)
St. Anthony's Hospital, Amarillo, Tex. (103 beds)
Methodist Hospital, Gary, Ind. (120 beds)
Ware County Hospital, Waycross, Ga. (78 beds)
Allen Memorial Hospital, Waterloo, Iowa (75 beds)
Saginaw General Hospital, Saginaw, Mich. (135 beds)
Frederick City Hospital, Frederick, Md. (125 beds)

inspiring in its community relationships, it will assume a definite personality."

Then follows a running account of the year's accomplishments as measured in terms of their improvement in the health of the people. Not a word is said about such matters as the coal consumed or the number of new curtains made. Rather, the attention is entirely centered upon the hospital as a health center and an education center for the Negroes of Louisiana and surrounding states.

Just look for a minute at the subheadings in the report: maternal and child welfare, tuberculosis, syphilis, Julius Rosenwald Fund and other contributions, women's auxiliary, N.Y.A. and W.P.A. projects, Penny-a-Day-Plan, educational programs (postgraduate courses for physicians, weekly seminars, public health institute for physicians, fellowships, residencies), nursing education, employes' health program, finances and statistics.

Names Should Be Included

Although the Flint-Goodridge report for 1941 does not include any list of names, J. L. Procope, the administrator, says that in his opinion "trustees and staff members should be included. Many authorities do not agree that this should be done but I believe it adds to the prestige of the men who serve in the institution. Furthermore, they like to see their names in the hospital reports."

A tabulation of the replies indicates that the majority of reporting hospitals favor the following items: a running account of the year's work; lists of trustees, medical staff, women's auxiliary, administrative staff and donors; the annual audit or financial statement (one aptly suggests that this should be kept brief); statistics of services rendered, and illustrations.

On the question of including an appeal for funds there was a sharp difference of opinion, six favoring such an appeal and five strongly opposing it. Mr. Procope, speaking for the latter group, states: "I do not believe a definite appeal for funds should be made in the annual report. Here and there in the report attention might be called to the fact that better work could be done in a particular department if more funds could be had for that project." This is a point of view often espoused by leaders in the field of hospital public relations.

Other items mentioned for possible inclusion in the report are: lists of diagnoses made and treatments given (a questionable practice in the view of publicists); specific needs for expansion and improvement; an account of building repairs and new equipment; a definite statement of the amount of charitable service; the religious work carried on in the hospital; information about the school of nursing or of technology; letters from grateful patients; mention of the various endowment, loan and scholarship funds, and separate reports of the various hospital departments.

Topics That Can Be Covered

In addition, the following subjects were suggested: credit to the voluntary assistance provided by the women's auxiliary, the medical staff and other groups; separate reports of the trustees, the public relations department and the women's auxiliary; information for patients; a history of the hospital; data and pictures of the various departments; an account of the observance of National Hospital Day; "Looking Forward" (a prediction of future developments of the hospital); religion and residence of patients; necrology of persons connected with the hospital; a report of the school of nursing. An even fuller check list of possible items will appear in the *Hospital Yearbook* for 1943.

Considerable confusion of thinking about the purpose and function of annual reports is apparent in this list. If they are intended merely as historical archives, hospitals are hardly justified in circulating them widely through the community because they will rarely be read. If they are intended as real aids in a public relations program, the material should be written and presented in such an interesting way that it will generally be read.

This latter purpose will be best fulfilled if the annual report consists primarily of a well-written running account of the year's work, all prepared from a single point of view and effectively illustrated with attractive human interest pictures. Statistics, financial reports and lists of all kinds that ought to be included should be placed in the back of the report where they do not clutter up the path of the reader.

Many of the annual reports of small hospitals could be greatly improved in both content and form if some kind of skilled professional advice were sought. While small hospitals usually cannot afford to employ a trained public relations consultant, such services can often be obtained without cost from volunteers.

If there is a good advertising man, a newspaper editor, a high class printer or the editor or layout man of a good magazine in the community, he might well be asked to assist in the preparation of the report.

"To whom should a hospital's annual report be sent?" This important question dictates in large measure the kind of report that should be prepared. From the answers it is apparent that most of the hospitals want their reports to be public relations assets. The recipients most frequently mentioned are: trustees (and members of the corporation, if any), benefactors and donors, medical staff, women's auxiliary, representative citizens, community and fraternal organizations, state, county and city officers, newspapers, hospital magazines, church groups, lawyers and law firms, other hospitals and social agencies, picked lists of former patients, nursing alumnae, general convention of the church, "people whom we wish to interest," hospital and medical associations, nursing bureaus, schools and colleges, public libraries, special friends, all interested persons.

One hospital suggests that at least 100 copies should be kept to take care of single requests.

Hospitals Want to Improve Reports

One outstanding fact disclosed by this inquiry is that small hospitals are eager to improve their annual reports. Several of them asked for specific suggestions as to how this can best be done.

In all such instances, the editors of The Modern Hospital are glad to give such advice and suggestions as they can within the time that is available. Hospitals of all sizes are invited to send us copies of their annual reports regularly. If special comment is desired, a request is in order.

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TRUSTEE FORUM

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Before You Increase RATES

Consider Other Ways of Increasing INCOME

HENRY J. SOUTHMAYD

DIRECTOR, DIVISION OF RURAL HOSPITALS
COMMONWEALTH FUND, NEW YORK CITY

THE exigencies of war fall with double weight upon civilian hospitals. Armed conflict multiplies a demand for services that only experienced hospital personnel can supply, and war, this time, comes in the midst of an unprecedented upsurge in civilian use of hospital facilities. It seems clear that both military and civilian demands cannot be fully met and, equally so, that civilian institutions must be adjusted to military necessity. The rising economic level, too, is complicating civilian hospital administration.

What appears to be causing most concern is increased operating expense, traceable chiefly to increased pay rolls, and the first reaction is that if standards are to be maintained new ways and means must be found to produce an equivalent increase in income.

The question immediately arises whether with the progressive depletion of personnel, present standards can be maintained, even by paying increased salaries and whether there will be a need for more income. It seems to have been overlooked that hospital earnings have increased with the decline of unemployment and the rise in wages, lending further doubt to the need for special steps to increase income.

Faced with rising costs and taking improved economic conditions as a signal that the people can and should pay more for hospital service, many hospital board members and administrators feel that a compensating increase in rates is the fair and obvious solution. It cannot be taken as a foregone conclusion, however, that increased rates will produce a like increase in income.

In order that the community hospital may be readily available to all and to encourage maximum use of the institution, rates vary over a wide range according to room accommodations. Since essential service is available at the lowest rates it may be expected, even under improved economic conditions, that higher rates will cause a shift from higher to lower priced accommodations and possibly some increase in collection losses.

The extent to which these effects may occur, naturally, is unpredictable, but it is believed that in some localities the result of higher rates in terms of earned cash receipts may prove disappointing.

In any event two other possibilities of increased income should be investigated before an increase is put into effect: (1) the prospects of increased earnings from self-pay patients at present rates, and (2) the likelihood of increasing voluntary contributions and allowances or appropriations from tax sources.

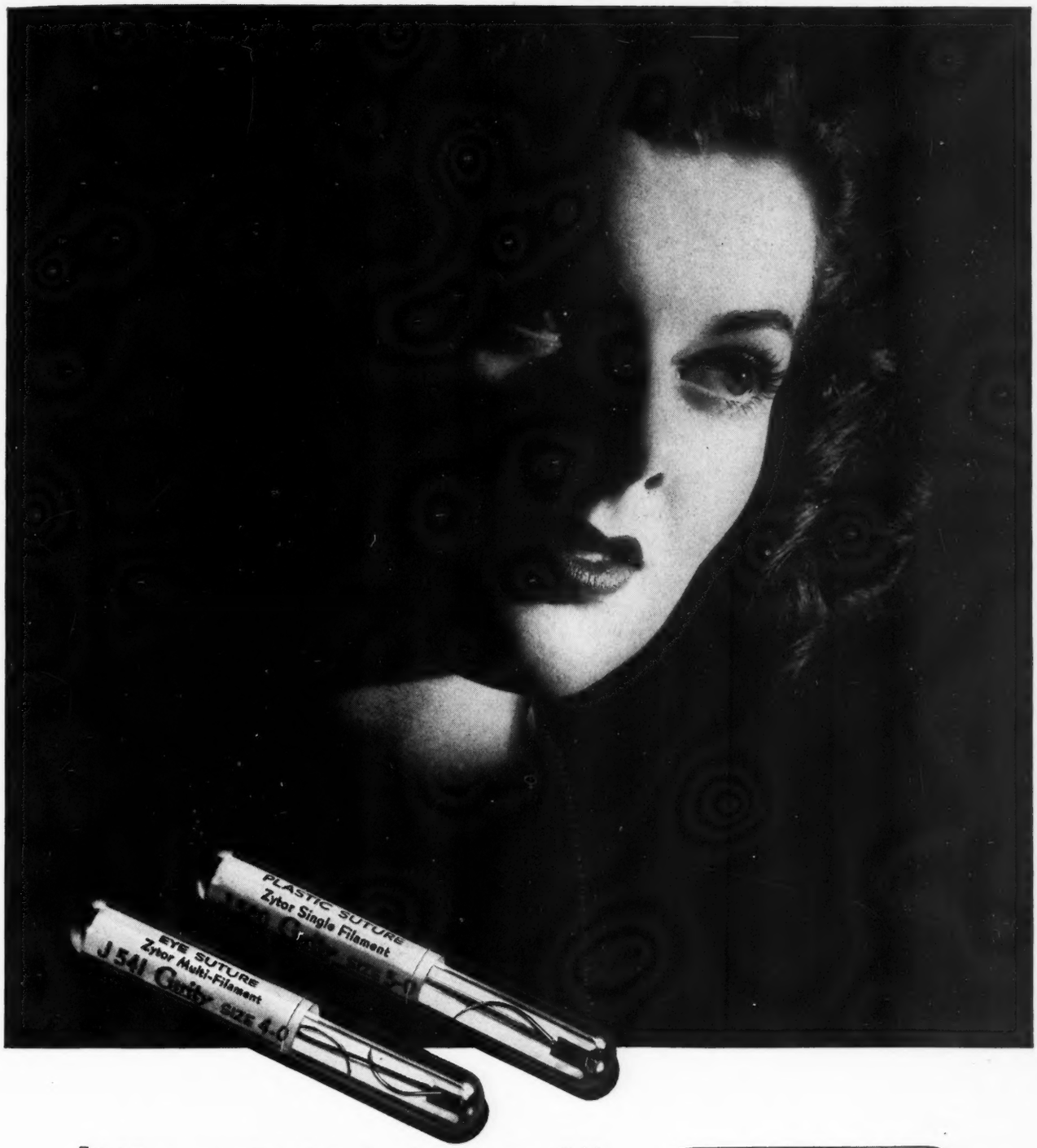
Comparing 1940 and 1941, earned cash receipts from self-pay patients in the Commonwealth Fund group of hospitals increased $73,000 while expenses increased only $60,000, a net gain of $13,000 in earned cash. During the first six months of 1942, expenses increased $64,000 over the same period in 1941, exceeding the increase from the previous full year by $4000. However, cash earnings more than kept pace with a rise of $70,000, a net gain of $6000 for the half year.

During the periods under comparison no rate increases were put into effect. The improved financial performance was accounted for by greater volume, a larger proportion of pay patients and better collections. With one exception, explained by a slight decrease in occupancy, all the hospitals in this group showed an increase in earned cash and, in the exceptional case, the decrease was only $12.

In another instance an apparent decrease of less than $500 between 1940 and 1941 was caused by a change in accounting policy which had the effect of reducing income from self-pay patients. In this hospital cash earnings increased $12,000 the first six months of 1942 over the same period in 1941 and it is safe to assume there was no real decrease between 1940 and 1941. Apparently, improved economic conditions up to this point have exerted an even greater effect on hospital income than they have on expense.

It is not entirely unreasonable to contemplate that earned cash at present rates might closely approach that which would be obtained from increased rates. These figures, too, may signify a gratifying willingness of the people to pay the most they can afford for hospital service and perhaps it would be wise in the long run to encourage that attitude rather than to dampen it with increased rates. Socially, it is certainly more desirable to have more patients paying their bills at lower rates than fewer at higher rates, and, financially, the difference in total income to the hospital may prove to be not worth while.

How community hospital income should be divided between earned income from self-pay patients (ward, semiprivate and private as a group) and unearned income made available for the care of the needy brings up a question of fundamental policy and



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its practical application. Ideally, the most that should be expected of the self-pay group is the cost of its care. Under this principle private and, in some cases, semiprivate patients make up the loss incurred by ward-pay patients, leaving the cost of caring for free patients as an obligation of the community at large. Practically, hospital rates and income cannot be so nicely balanced and, often, earnings from all types of self-pay patients exceed the cost of their care. The hospital board must make two decisions at this juncture:

1. Whether it will abide by the eminently fair and clear-cut principle that the cost of free care is a community-wide obligation or—

2. Whether the fixed policy shall be to minimize the community obligation at the expense of self-pay patients.

A case in point recently observed is one in which rates were marked up steeply while surplus earnings from self-pay patients under the old rates were already contributing one fourth of the cost of free patients.

In this instance, I believe that the increase was wholly unwarranted. It is my distinct impression that the inclination to increase hospital rates at the present time frequently is not unmixed with a desire to transfer a still greater part of the community burden to self-pay patients in pursuit of the mistaken idea that a community hospital should "pay its way."

Comparatively few residents of rural and semirural areas can afford the cost of their own care without undue hardship and if present rates provide excess income from the self-pay group, no increase seems to be justified.

Because of the doubtful need and questionable effect of rate increases and because in most cases this action would further burden pay patients with the care of the poor, it is recommended that the income budget be based on existing rates and that increase in the expense budget be no greater than that earned from present rates.

Admittedly, this formula may call for reduction in personnel and some sacrifice in standards, but that, in all probability, is an eventuality that hospitals can no more escape than can any other civilian activity in these times. The adoption of this policy would require no change in present income from contributions and taxes; moreover, it would be in accord with good national policy for combating inflation.

As will have been gathered, I believe the threatened shortage of hospital personnel, independent of its financial implications, is the most important problem hospitals must solve. Assuming that reported plans for expanding the national military establishment go forward, a serious dearth of hospital personnel is imminent. Therefore, plans for preserving essential standards, so far as possible, with a radically reduced number of experienced personnel should receive first attention. A thoroughgoing effort to eliminate nonessential and time-consuming procedures should be undertaken at once. Reading of current hospital literature on this subject, including articles by E. L. Harmon, M.D., and Roger W. DeBusk, M.D., in the May and July 1942 issues of The Modern Hospital, should be helpful.

Some of the Commonwealth Fund hospitals that anticipated the need of replacing trained and experienced personnel over the last two years have been successful in training lay and voluntary assistants in all departments of the hospital. Institutions that have not developed these programs as fully as possible should redouble their efforts to do so.

While it may be too much to say that the shortage of professional personnel may soon become so serious that the hospital will be forced to limit admissions of civilian patients to emergencies and the most serious illnesses, that eventuality, too, should be anticipated. The reduced number of physicians for civilian practice presents a perplexing problem. On one hand, it would seem wise to encourage the few remaining in the community to refer the largest possible number of patients to the hospital in order to conserve the physicians' time and strength. If, however, because of the lack of trained and experienced personnel that course involves a question of indifferent hospital care to the many against good care to the few more seriously ill, unquestionably, admissions should be limited.

In this emergency the hospital should curtail its demands upon the staff physician and make its facilities available to him for his home and office practice so far as local conditions at the time require and permit.

WOMEN'S SERVICE GROUPS

Hardly a month goes by without the women's auxiliary of Mercy Hospital, Chicago, supplying funds for the purchase of some needed piece of equipment. A recent gift was a station wagon and the hospital has just built a special shelter for its protection. A neighborhood merchant donated a set of tire locks for the wagon.

The hospital has a newly decorated space called the Victory Room where the women's auxiliary and the hospital auxiliary's Red Cross production unit come to work and meet.

• •

Hospital administrators and directors of volunteer service keep writing to the editors for new ways to use volunteers. Here is how St. Luke's Hospital, New York City, uses a large quota of volunteers, exclusive of members of the American Red Cross Motor Corps.

On the nursing service in the month reported on, St. Luke's used 39 nurses' aides, graduates of the Red Cross course.

In the accounting department, one volunteer took care of the compilation of hospital statistics through the use of punch cards.

One volunteer served mornings as secretary to the chief dietitian.

In the laboratory, two volunteers did clerical work and five apprentices did routine laboratory work under supervision (three of these were premedical students).

Three file clerks did volunteer work in the medical records department.

In the out-patient department 25 clinical clerks worked in the various clinics.

One volunteer in the patients' library took the book cart through the wards three times a week.

In the operating suite, one volunteer made plaster bandages three mornings a week for the orthopedic service.

In the physical therapy department two volunteers took over the work of escorting patients to and from the wards.

Five volunteers made bandages in the sterile supply room.

That makes 10 departments in which volunteers helped to make up for the losses in hospital manpower.

Milestones in 7 *Medical History*

1941

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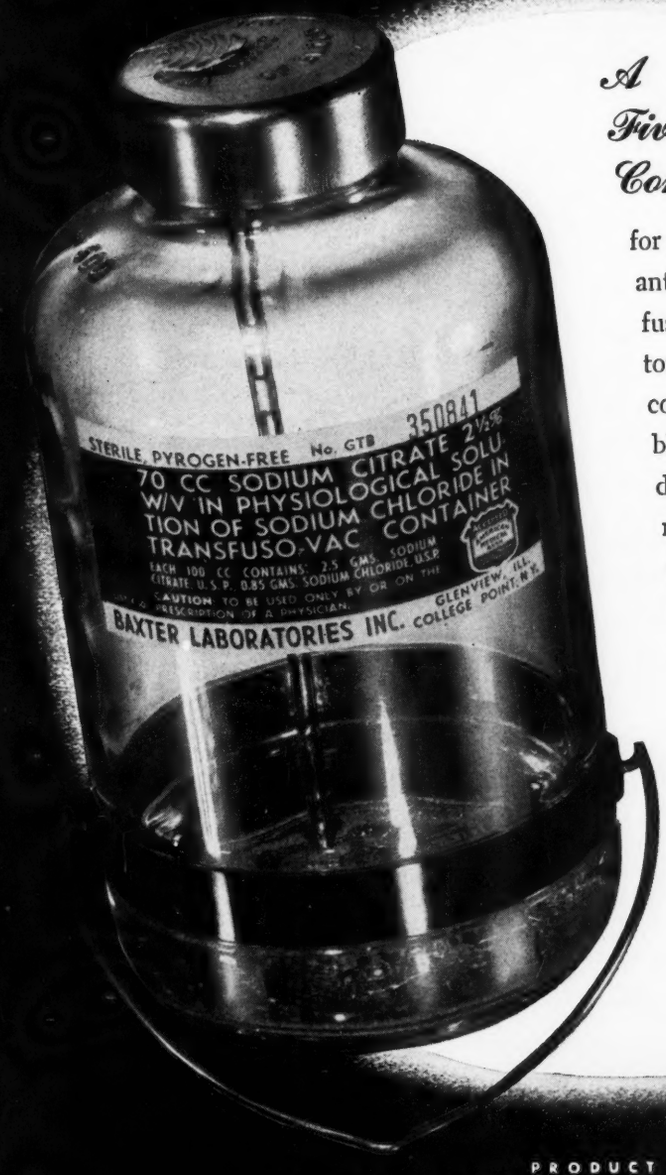
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Memo to: Maintenance Engineers *Subject:* CONSERVATION

From: **WILLIAM OVERTON**

SUPERVISING ENGINEER

MONTEFIORE HOSPITAL, NEW YORK CITY

THE rapid depletion of the supply of skilled labor, caused by the demands of our production program, and the shortage of materials are daily becoming more evident and of genuine concern to all of us. The situation for hospitals in this respect has become acute and calls for a complete revolution of methods of approach to our maintenance problems. The following suggestions for conserving manpower and materials may prove helpful.

Personnel

In almost every department there are mechanically inclined persons who can be trained to replace those who have beeen called into the armed forces or have gone into industry. Draft status and age should be the deciding factors in their selection. It is advisable at this time to take into consideration the employment of older men who have some mechanical ability. Our labor needs today must be approached with methods of today.

A good example of success in this respect might be pointed out in the case of some of the large shipbuilders on the West Coast and in the South; they engaged key men and then trained mechanically inclined laymen, some of whom had never seen a blueprint, instructed them in the exact requirements of the job and drove the matter home by the use of symmetrical drawings.

If an employe is not satisfied with his present duties in the institution, the personnel department or another authority should see to it that he is consulted with and placed in the department that offers the best outlet for his talents.

Institutions that care for the physically handicapped are a source of supply for skilled artisans. Likewise, delinquent adults incarcerated for minor or first offenses against society have proved satisfactory at Montefiore Hospital, New York City, from the viewpoints of both rehabilitation and the reaction of the individual in performance and faithfulness to duty.

Adjustment of wages to meet competition in other fields should be seriously considered. The employment of women wherever possible is recommended.

An educational program must be put into operation to impress upon the individual employe the importance of preserving the equipment and materials we now have and their tremendous value to the hospital. All department heads should make careful periodic inspections and, if there is the slightest sign of trouble, any repairs should be made at once, thereby preventing breakdown and the use of more vital materials.

The danger of a complete shutdown of an essential piece of equipment can be averted by observation of performance and the making of timely repairs. All employes must be on guard and report to the department head any irregularity of action or operation of equipment.

Emergency methods must be adopted in specific instances. For example, an alert employe welded a motor armature shaft that had a flaw and eventually ruptured. This welding job was completed at a nominal cost, whereas replacement of the armature would have cost $150. New parts should not be ordered if it is possible to repair or weld old parts.

Maintenance and Repairs

Sterilizers—The cover-raising mechanism of hydraulic or other instrument and utility sterilizers should be taken out, inspected and cleaned periodically and old oil should be replaced with new. All other repairs should be effected when units are sent to the shop for checking. The steam generator of drum and autoclave sterilizers of the steam-generating type should be removed and cleaned internally. Over a long period of use the steam-generating coils and cylinder may become encrusted with scale that reduces the efficiency considerably. The reducing pressure valves and return valves should be kept in good order. Leaking traps waste a great deal of steam; door gaskets should also be examined to prevent leakage of steam and to make certain that the vacuum is maintained.

Electrical Equipment—Electrical equipment, especially units that are no longer available, should be inspected frequently. Electric motors should be cleaned and armature and field coils should be blown by air with either hand bellows or some mechanical means. Oil should be drained from the bearing oil wells and the wells cleaned and refilled with fresh clean oil. The oil ring or chain should be examined to see that it turns freely on the shaft. This ring, which revolves with the shaft, carries the lubrication to the bearing.

Laundry Equipment—Laundry equipment is usually built to withstand abuse but there is likely to be

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COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

a general breakdown at some time or other. The door catches and supply valves, including dump valves, should be kept in good order. The washing trunnion bearings carry the internal drum and load of material to be washed. These bearings will run approximately three years without any maintenance. At the end of this time, they should be taken out, cleaned, rechecked with grease and packed to keep the interior washing waters from impregnating them.

Extractors travel at high velocity and often are not balanced when loaded. This creates extra wear on the rubbers that carry the basket, whether it is of the balancing or vertical hung type. Rubbers should be removed and examined for signs of wear and, if necessary, replaced by material that may be available. The bottom thrust bearing should be taken out, cleaned and repacked in new grease.

Consideration should be given to drying tumbler bearings as they have to withstand a high temperature and, generally, some of the equipment has to travel at a high speed. These high speed bearings should be examined quite frequently and cleaned and repacked with a special type of grease.

Mangles of from one to eight rolls, regardless of size, require the same attention. The chests should be kept clean to prevent a sticky adhesion. Gear housing should be taken off semiannually and cleaned. This includes the hood over the mangle and the duct of the hood. Should any of these parts be neglected and in some way become ignited, the flames will spread rapidly. Proper adjustment of presses and of the driving mechanisms should be maintained. Good housekeeping of laundry machinery is essential.

Elevator Machinery—Hoisting and counterweight cables should be inspected and kept free of grit and dirt; these cables pass over sheaves with a heavy weight attached on each end and, consequently, the grit and dirt can grind the cable against the steel sheave, thereby decreasing the life of the cable. They should be cleaned and oiled from time to time. The elevator guides and rails should be cleaned and greased as required to prevent wear. Inspection of elevator contacts and adjustments should be made daily. The oil in the moving driving mechanism should be changed frequently. Safety appliances, such as door locks and door closing devices, should be inspected at least once a day.

The number of elevator trips should be curtailed. Elevators travel several miles daily because employes use them for only one or two floors instead of walking. The functional part of an elevator consists of copper and steel. The increased wear of steel hoisting and counterweight cable shortens their life and more frequent replacements are necessary.

Engine Room Equipment—Boilers should be cleaned internally and externally to produce the highest efficiency. The boiler setting should be made tight by calking the cracks in openings to prevent the outside air from infiltrating into the inside of combustion chamber. A film of $\frac{1}{16}$ inch on the interior of the boiler will create a fuel loss of approximately 5 per cent, and a dirty exterior will decrease the efficiency another 5 per cent. All mechanical apparatus in the boiler and engine room should be kept clean and in first-class operating condition.

Refrigerators—The main refrigeration unit should be overhauled once a year and condensers should be cleaned at this time. This work should be done during the winter months when the refrigerating plant carries a light load. Utility refrigerating units should be inspected annually to see that the proper amount of refrigerating gas is supplied and

Engineers' Question Box

Do Freon and Ammonia Lines Leak?

Question 25: What tests should I use for leaks in the ammonia line and for leaks in the freon lines?—L.M.W., Iowa.

ANSWER: To test freon leaks, use a leak detector torch or instrument with special pressure reducer and leak detector head. To test for ammonia leaks, use litmus paper or oil and watch for bubbles. To test for CO_2 leaks, use soapy water or oil and watch for bubbles. —JOHN A. DOHERTY, *superintendent of buildings and grounds, Cambridge Hospital, Cambridge, Mass.*

Testing Radiator Traps

Question 33: How would you test thermostatic radiator traps?—W.J.M., Ohio.

ANSWER: Install a steam reducing valve from zero to 15 pounds' pressure. Connect a half inch valve and a radiator trap complete. Connect the discharge side with a nipple to a bucket to catch the condensate. Turn on the steam valve. If the steam trap is all right it will not blow through and in a few minutes it will discharge the condensate into the bucket and seal itself. If the trap continues to blow, however, the trouble may be caused by scale under the seat of the body or by a ridged needle point seat because of drawn wire or punctured bellows. In such cases the trap is no good.

Another good way to test a steam trap is to touch one hand to the steam entrance of the trap and the other hand to the discharge side. If there is a difference in temperature, the trap is in working order. In addition, the body can be unscrewed from the shake. If it rattles it is best to change it; otherwise, it will be noisy on the risers.—EDWARD W. SILVERMAN, *assistant engineer, Mount Sinai Hospital, Philadelphia.*

Valves of Substitute Materials

Question 39: In view of the rubber shortage I am worried about replacing the dump valves on our laundry washers. Is there anything I can use in place of rubber?—R.C., Ark.

ANSWER: Such equipment as valves, rubber gloves, tubing and hosing are now available in substitute materials that, in many cases, last longer than the original rubber products.—E. W. RIESBECK, *consulting and construction engineer, Chicago.*

RIESBECK OF CHICAGO IS WINNER

E. W. Riesbeck, M.E., consulting and construction engineer of Chicago, is the winner of the monthly $5 prize for the Engineers' Question Box for December. His answer on preserving the metal in air washer pans in the ventilating system is not only a useful economy but also of particular importance today when all metal must be carefully conserved.

THE NEW WESLEY MEMORIAL HOSPITAL

NATIONAL NAVAL MEDICAL CENTER

THE MEDICAL AND DENTAL BUILDING

MODERN HOSPITALS

are ELKAY Equipped

In order to render the best possible service and safeguard the health and welfare of its patients, the equipment in the modern hospital is specially designed to meet the technical and professional requirements of its staff. That's why in so many modern hospitals ELKAY "Sturdibilt" Stainless Steel equipment is so widely used.

Its stain-and-acid resisting surface assures the utmost in sanitation while its sturdy, electrically welded and reinforced construction assures a lifetime of service and low maintenance cost.

The installations shown here include hydro-therapy tanks, cabinet sinks and tops, an arm bath, an autopsy table, also service room and other laboratory equipment in the National Naval Medical Center, Bethesda, Md.; the new Wesley Memorial Hospital, Chicago; and the Medical and Dental Building of the University of Illinois, Chicago.

We invite your inquiries. Our engineers will gladly submit plans and estimates

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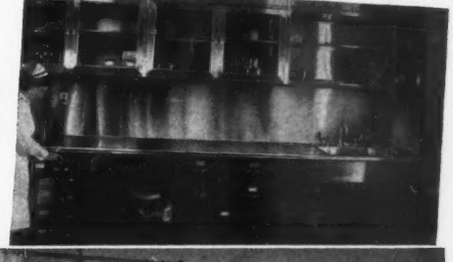
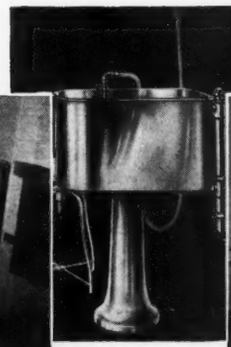




INSTALLATIONS IN THE NATIONAL NAVAL MEDICAL CENTER ARE FROM U. S. OFFICIAL PHOTOGRAPHS

COOPERATION WILL WIN THIS WAR—*Get Into the Fight With Your Scrap*

the automatic controls are functioning properly.

Kitchen Equipment — Mechanical mixers, meat grinders, electric food trucks, sinks, gas ranges and numerous other items should be inspected and cleaned periodically. Kitchen hoods and ducts should be cleaned semiannually to prevent fire hazards, as grease may be spilled, resulting in a film that may be ignited.

Steam Lines—Leaks in steam lines should be attended to at once. Pipe lines must be covered to prevent undue radiation and loss of heat, which, in turn, mean loss of fuel. The night watchman should turn off steam in unused areas on his first round at night and turn it on again in the morning.

The use of hot water should be carefully watched. Hot water waste means loss of the heating agent. Employes who ordinarily use large volumes of hot water should be mindful of abuses and cooperate in every way possible to eliminate them. Laundry formulas can be revised to reduce waste by employing the proper number of washings and rinses, in accordance with the amount of soil in the linen, thereby not only conserving water but prolonging the life of the linen. It is difficult to limit the use of hot water in the hospital but, with careful thought, a great deal of waste can be avoided.

The second section of Mr. Overton's article will appear in the February issue.

HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

Save That Rubber Floor

Owners of rubber flooring, like motorists, have a definite responsibility for conserving the precious material, it is pointed out by a floor maintenance manufacturer. Methods of extending the usefulness of rubber flooring are set forth in a recent issue of the organization's house magazine.

The proper way to clean rubber floors is with a mild alkaline cleaner. Alkalies do not injure rubber as they do linoleum and wood, but because of certain ingredients sometimes used in the manufacture of rubber tile strong alkalies have a deleterious effect and should not be used continuously. However, the milder alkalies, such as the crystalline modified soda type, are safe agents for rubber floors.

Abrasive cleaners are not good for rubber floors because they remove the natural plate finish. If the plate finish is already worn away, it may be necessary occasionally to use an abrasive—but only on some stubborn stain or soil that cannot be removed otherwise.

The less water the better is the dictum of this manufacturer. Water seeps down between the edges of the rubber tiles and causes a certain amount of disintegration, not so much of the rubber itself but of some of the other ingredients used in the manufacture of the tile. Too much moisture also has a tendency to deteriorate the cement that holds the rubber tile to the floor and, occasionally, even warps the floor underneath.

It is necessary to clean rubber floors with water sometimes, but it should be done as seldom as possible. Occasional waxing not only cuts down on the need for cleaning with water but actually protects the surface of the floor.

It is a good idea to consult the list of approved waxes issued by the Rubber Manufacturers' Association before purchasing this type of material. The association does not endorse the waxes listed but simply indicates that they will not injure rubber floors.

Never, in any case, use a cleaner of the spirit or oil varnish or spirit lacquer type on a rubber floor, it is warned, because it will rapidly hasten the end of the usefulness of the floor. If a rubber floor is so badly worn that it is not possible to obtain the desired results with any of the self-polishing water waxes, one of the incomplete emulsion type of water waxes that require buffing should be used. Two or three applications of this wax buffed into the floor will usually restore a semblance of the original plate finish, after which maintenance can be continued with a self-polishing wax.

To avoid the slipping hazard caused by waxing, remember that two coats are less likely to be slippery than is one.

● ●

Vermin Stay Exterminated

Having insect and rodent trouble? Mrs. Julia Siebert, house manager of Winfield Sanatorium, Winfield, Ill., arises with a sure-fire extermination method.

"Some years ago," she writes, "after all the methods we tried had failed to exterminate vermin and rodents permanently, we adopted the plan of employing a reliable exterminating service. We have enjoyed freedom from these pests ever since."

● ●

Department Heads in Harmony

As long as we insist on behaving like human beings there is likely to be a certain amount of friction in any large organization where a number of differing temperaments and personalities come into contact—or conflict.

According to Winifred Bradford, Milwaukee Sanitarium, Wauwatosa, Wis., there is no golden rule for avoiding friction between the housekeeping and nursing or the housekeeping and engineering departments.

"In all probability," Mrs. Bradford contends, "too much emphasis is laid on interdepartmental friction. The trouble is a very human one; heads of departments are almost of necessity strong characters and, being human, they 'want what they want when they want it.' Possibly, the help of a wise and understanding administrator is part of the answer, plus good judgment and the ability of the department heads to forget when 'scraps' are over.

"Maybe the greatest fault of department heads lies in not viewing their own divisions in relation to the whole organization. No department is sufficient unto itself or an end in itself but is only a complement to the other departments. Smoothness of working together should be the desired goal.

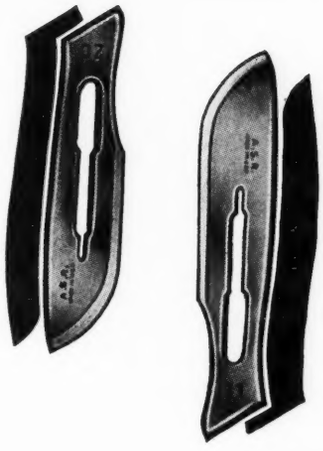
"Overlapping of authority is not usually conducive to harmony and should be eliminated insofar as possible. Divided authority is usually harder on the employe than it is on the department head."

From Mrs. Vera J. Frey, director of housekeeping and laundry at Grace Hospital, New Haven, Conn., comes the suggestion that all interdepartmental disputes should be settled by the administrator.

"The administrator should clearly outline the area of operations and responsibilities to each department head and should see that they are adhered to. There should be no question of overlapping authority, since in any matter involving interdepartmental dispute the administrator should assume full control and designate which department should have precedence.

"A simple way to solve such problems would be to have a meeting of all department heads at regular intervals—once a week, once a month or as often as necessary. At this time executive problems can be discussed. An understanding of one another's problems would simplify many things and help to correct any misconceptions that one might have regarding the other fellow's job."

There Are No "MINOR DETAILS" in Surgery



"Everything connected with an operation is important! That's why it's more than just a surgeon's psychosis when I insist on A. S. R. Surgeon's Blades. I feel better, work more easily, confident in their never-deviating keenness; their standard of high quality; the A. S. R. reputation of never permitting an inferior blade to reach surgery." Rate the blade you use against A. S. R. Surgeon's Blades. Check your regular supplier for full details.

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FOOD SERVICE

War-Time Economy in the Kitchen

Suggestions to help dietitians faced with the problem of doing more—with less

MARY E. McKELVEY
DIETITIAN
UNIVERSITY HOSPITAL, ANN ARBOR, MICH.

MOST of us are facing a combination of conditions that did not exist heretofore. The problems of adjustment in all phases of institutional life are so interlaced that it behooves each department head to have a complete knowledge of the needs and problems of his neighbor's departments, as well as of his own.

Trained personnel has become so depleted in all units that the remnants left are not sufficient to train and direct adequately the untrained and possibly illiterate or afflicted workers who replace those who have gone into military service or into better paid industries. While it is now too late to attract employes who are qualified to fill such vacancies, it is not too late to endeavor to retain those remaining who are not only well trained in, but familiar with, the activities of the hospital.

Salary adjustments to the extent permitted by federal ruling should be made and a plan should be provided to take care of the overtime work of both the monthly and the hourly wage earner. It is no longer possible to make up overtime by giving extra time off to the monthly worker. His present attitude toward overtime is one of dissatisfaction and unhappiness, yet he would gladly increase his earning capacity by working overtime as the hourly worker does, if he were paid for it in additional wage.

Such adjustment will be difficult, to be sure, but since this is the group that is bearing a great part of the burden of keeping the unit functioning it is only fair to make some equitable provision. No doubt it would be the means of retaining certain of these workers in positions in which they are sadly needed.

In the University Hospital, Ann Arbor, Mich., we pay the hourly wage earner the same wage for overtime as for regular time. Were we not able to pay for overtime the workers in this group would not consider working on days off or overtime; as it is, with few exceptions they are glad to do it and it has proved our salvation.

As male workers became fewer, we have employed female help wherever possible. This has called for definite reorganization of jobs, as our kitchen was planned and equipped for male help. We formerly employed two women in the main kitchen, now we have six; in some instances, depending upon the individual worker, it has been an improvement rather than a hindrance. However, it is not possible to carry this plan further because it interferes with our ability to shift employes to other vacancies, a problem that has become more acute as workers become more transient.

The problem of training the new employe has progressed far beyond the point of control. We all know that he should be trained by the supervisor in charge, but when there are always four or five new ones who stay perhaps a day or two we cannot train them properly. However, well-organized explicit routine cards are a great help if the employe can read.

Most of the new workers in hospitals are there because there is no place for them in industry owing to physical affliction, illiteracy or old age. Last summer one of our best workers was a high school boy who was far more mature than his age indicated. We should not be skeptical of youth, neither should we influence boys of this age to continue working instead of returning to school. Sometimes, however, youngsters can be used as week-end relief workers.

Menu adjustments to meet the less skilled workers' ability have been necessary. It is better to have a simple dish, well and attractively prepared and served than a more elaborate one that fails because of lack of skill in its preparation and service.

At a time when we should conserve all effort and expend it only where it will bring our institutions a threefold return, we find ourselves frantically trying to cover from meal to meal. We are endeavoring to educate these new workers in sanitation, personal responsibility and integrity toward the unfortunates who are patients in our hospitals. To accomplish this we need not only the sympathetic understanding of our hospital administrators but an active knowledge of what constitutes the activities and preparation that are necessary before a tray is placed before a patient.

It is apparent that personnel has become one of the most vital of the many problems confronting administrators. Pot washers and kitchen helpers are important people in any institutional kitchen, yet too seldom is this fact recognized by the employment bureau. If an analysis of each job were on file it would aid materially in the selection of workers to meet the specific needs of the various units. Need for an organization to cover week-end and holi-

From a speech delivered before the American Hospital Association, October 1942.

day workers' absences has become acute because workers are absenting themselves more and more on such occasions. The employment office could supply information necessary to locate workers who are legitimately off duty but are willing to help meet the emergency shortage by assisting in departments other than their own.

While under normal conditions I do not advocate employes' not having regular time off duty, the emergency is becoming so critical and the supply of workers so meager that overtime has been and will be necessary if hospitals are to be maintained. Although volunteer help is used in some departments for serving and feeding helpless patients, it is doubtful whether the preparation unit could depend upon this type of help to carry on the needed activities.

Equipment Must Be Conserved

Along with the problem of personnel comes the equipment problem. With the shortage of manpower it would be helpful to use more labor-saving machines, but with supplies restricted by government control this is beyond consideration. It behooves us, therefore, to make every possible effort to maintain present equipment and postpone as long as possible that time when it will no longer be usable. We know that the life of equipment is prolonged and its service is greatly enhanced if it is given proper care. To accomplish this it is necessary to have intelligent employes who can be taught what to do and who have integrity and judgment.

Cleaning, thorough drying and regular oiling of all machinery with movable parts will ensure added life. Mineral oil is recommended for use on such machines as vegetable dicers, food choppers and grinders as it is tasteless, harmless and odorless.

Motors and gears of mixers should be oiled and greased regularly; worn parts must be replaced, bowls should be kept dry and whips should be hung on racks to prevent damage to wires; always, the machine should be started at low speed.

Meats used in choppers and grinders must be free from bone because a small bone will break the chopping or grinding knife, which is difficult to replace at this time.

Steamers with stainless metal interiors should be well hosed and dried after use. If they are made of iron, they should be painted once a year with some suitable coverings, such as aluminum paint mixed with water. See that gaskets are kept replaced and hinges are clean and well oiled.

Potato peelers should be thoroughly cleaned by hosing, if possible, or by scrubbing and drying. The motors should be greased and oiled, the revolving disk and liners should be replaced when needed and the machine must never be overloaded.

Sinks, metal tables, counters and steam tables with soldered joints must be resoldered the minute any break is detected. If the equipment is of stainless metal, immaculate care is necessary to keep it in top condition. It must be cleaned throughout once a day with a scratchless powder or liquid, for scratches show quickly on this highly polished metal. If galvanized iron is used it should be dried thoroughly or corrosion will quickly destroy it.

With the shortage of cutlery, no knife should be discarded. It can be resharpened or repointed if it is broken and in most cases a handle can be replaced. While plastic knives are coming into domestic use they are not yet available to any extent for institutions.

Any old silver should be reclaimed; fork tines can be straightened and other repairs made if replating is possible. No more replating on 18 per cent nickel base is now being done by manufacturers. At the present time a plain steel base is being used. This rusts badly so that silver must be washed and dried quickly.

Since certain chemicals used in the process of decalcomania are becoming scarce, it would be well to obtain all china necessary for the duration as there is a possibility that only plain, unadorned china will be produced in any great amounts.

Cooking utensils of aluminum, tin and steel are not being produced and most of the stock on hand has been put into use. Some enamelware is obtainable but because of its steel base the supply is limited.

Work on the perfection of unbreakable glass is progressing, but not to such an extent that it can be satisfactorily substituted for general use. The cost, too, makes it something to be admired rather than used.

With conditions as they are, it is unwise to discard even leaking containers. Mark them with a splash of bright colored enamel paint that will stand washing and use them for storage of dry products. Lacquer-lined tin cans, x-ray developer cans, with close-fitting covers, and frozen fruit cans make excellent storage containers for refrigerated foods or cereals and will free aluminum-covered containers for use on carts or delivery to other units.

Utility Companies Will Help

Many utility companies furnish the services of maintenance men to check gas and electric equipment. This service is valuable at any time, but doubly so now. The judgment of the service men on replacement of needed parts is based upon the best performance of their representative equipment at least expense. They can relieve institutions of that particular phase of the work.

The general care is the hospital's problem. Gas stove tops, burners and ovens need to be cleaned daily. They should be washed with soap or a fat-dissolving chemical, if possible, then polished with steel wool, rinsed and thoroughly dried. Often, a student can be employed several hours each evening to do this work when the stoves are cool. He must be trained, however, as he may be working with no supervision.

Electric ovens must be checked continuously by an electrician. The moisture from bakery products affects the wires and, often, wide variance in heat control will develop in a short time, causing failure in the foods produced.

When there is any doubt as to the correct procedure in handling a piece of equipment always call on the manufacturer. Do not resort to experimentation or "trial and error" methods. Equipment firms are only too glad to give information and help in this manner; many make a definite point of advertising this service to their customers.

In the problem of budget adjustment in war time, we have the same principle of production of maximal

nutritional values at minimum costs that we have in peace time, with the addition of many factors that are not normally considered. It involves not only the purchasing, processing and serving of food but the control of all the procedures that are concerned with the food service.

It is not possible at this time either to predict or to advise what substitutes to use for foods of higher price. Government control and freezing of certain items contribute to this situation.

The cost of sugar is not prohibitive, but corn syrup and honey as substitutes definitely increase the ingredient cost of the product. The sensible attitude is to cut down the use of sugar. It can be done and a high food standard can still be maintained. Use less icing; soak evaporated fruits from twenty-four to thirty-six hours and cook them slowly with no added sugar. Leave desserts that have extravagant amounts of sugar off the menu, and include all the fresh fruit possible.

Corn Sugar Is Good Substitute

The one substitute for sugar that we have found adequate, yet equally economical, is corn sugar used in the same quantity as cane sugar formerly used in the "sweet dough" and bread products made in our hospital bakery. Since we produce all the bakery goods on our menus, it has been a means of conserving about 200 pounds of cane sugar per month. If corn syrup is being used —we, too, were panicky in the beginning — it is less expensive if bought by the barrel than by the gallon.

With meat rationing in prospect, further adjustments will be forced upon us. Fresh fish and sea foods are no longer inexpensive substitutes. Canned salmon, tuna, crab and shrimp not only are expensive but are not obtainable in amounts needed in large institutions. Eggs and cheese have increased in price. Chicken is plentiful, but with the soaring of its price roasting chickens have become a luxury. This means that only dishes of an extended type are possible if the budget is to be in balance.

When meat is served weighed portions may be a means of conservation and waste prevention. Some commercial cafeterias and restaurants are weighing all meat portions served. However, this may create the necessity for additional equipment.

Soy beans as meat protein substitutes can be used as luncheon dishes for baked beans, in vegetable casseroles and in soups. Soy bean meal in meat loaf as a meat extender and soy bean flour in bread, muffins and cookies are other uses. We have had difficulty in obtaining a good quality of the edible variety, but the new crop is now available.

How to Prepare Vegetables

Vegetables and their preparation involve not only labor but skill. The fresh vegetable must be delivered, refrigerated, prepared and served with minimum loss of the product itself and of the nutrients that it contains. The great variance of nutritive value is due to the differences of storage and methods of handling and cooking.

It is unwise to peel potatoes or other root vegetables a day ahead and allow them to stand in water overnight as mineral and vitamin content is lost. Baked and steamed potatoes with skins so well scrubbed that they glisten lose little of these precious body needs when served in this way. Carrots, parsnips and other long vegetables cut lengthwise rather than in slices or cubes lose less nutrient value. Vegetables should be cooked in as little water as possible and the cooking water retained for use in gravies, soups and sauces.

Head lettuce should be served in sections rather than shredded; if vegetables for salads are chopped or shredded, this should not be done far in advance as the shredding or chopping breaks down the cell walls and oxidation of vitamins occurs. Nor should orange juice be squeezed far in advance of use; if the labor situation necessitates advance preparation it should be kept in a glass container, tightly sealed with an airtight cover.

While the price of ice cream mix has increased along with the price of other products, as long as it is available it is the basis of one of the least expensive desserts, besides being nutritious and popular. Curtailing the use of sauces constitutes another saving that is worthy of consideration.

The present period of stress is revealing many weaknesses in institutional organization of which we have been unaware and which have an effect upon the economic expenditure. They will need skillful handling and study. In purchasing, no longer is the customer always right; rather, the customer is the one who must make the adjustment now to adapt his needs to what can be supplied. This necessitates the development of standards for all commodities that may serve a given purpose and also for commodities that may be used as substitutes.

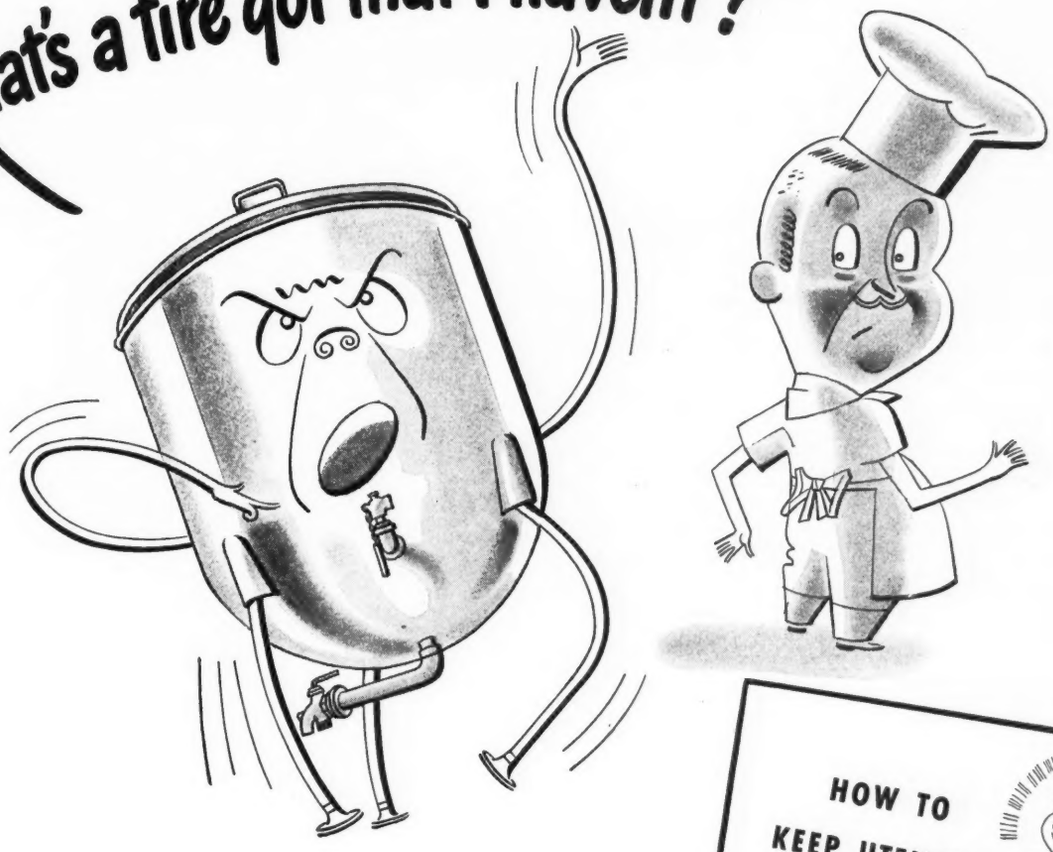
All samples submitted should be checked and graded on a quality price basis and a record should be kept; then, if the desired grade is not obtainable, a substitute can be selected from this commodity list with little loss of time. It is no longer possible to estimate accurately the advance meal cost since we are not able to buy exactly what has been planned. Fresh plums, peaches, pears and oranges on the market do not run true to count, for example; hence the cost is variable and not true to the anticipated cost. This is proving true of more commodities daily. We take what we can get and use it as best we can.

Nothing Should Be Wasted

We must let no discarded fat go down the sewer. We must sell used soup bones to fertilizer companies and garbage to pork producers. Time, energy, equipment and foodstuffs are valuable. We must look through records and continue to keep only those that are vital. Clerical service is scarce; therefore, requisitions should be made clearly and concisely and speeded to the department in which they are to be filled with as little red tape and loss of time as possible.

The hospital kitchen budget is a large factor in the institutional budget and we must carefully plan for the maintenance, conservation and standardization of this department's needs. We must endeavor to utilize faithfully the manpower, equipment and professional ability we have to produce the greatest good for the greatest number. We must not consider personal gain if we are to do our part to carry on through the difficult days—now and in the future.

What's a tire got that I haven't?



That's a fair question! You hear a lot about saving tires but little about making Aluminum Utensils last as long as possible. Doing both is important.

It's not just that Aluminum Utensils are scarce, aren't being made again till after the war. It is actually a double saving to take good care of your Aluminum.

First, you save having to buy new utensils. Second, you save food. By having good Aluminum that spreads heat evenly without hot spots, you cut down waste from scorching and burning.

In fact there's a third good reason for making your utensils see you through. When the war is over and the Wear-Ever plant switches back to pots and pans, they are going to be 'way ahead of any you've ever seen. You are going to want these new, improved utensils because they will cut the cost and raise the quality of your cooking.

HOW TO KEEP UTENSILS HAPPY

1. Treat your Wear-Ever Utensils with the same respect you give other fine equipment.
2. Don't mistreat them by needless rough handling.
3. Clean your Wear-Ever Aluminum thoroughly and properly.
4. Flatten out accidental dents to avoid excessive wear. Place a wood block over dent and pound with a hammer.
5. Watch for loosening rivets and tighten them before it's too late.

TO CAUTION YOUR HELP, these and other reminders have been printed on 11 x 14-inch cards to hang in your kitchen. How many can you use? For these cards, or for advice on any special maintenance problems you may have, write THE ALUMINUM COOKING UTENSIL COMPANY, 701 Wear-Ever Building, New Kensington, Pennsylvania.

Wear-Ever Aluminum

WEAR-EVER ALUMINUM TRADE MARK REG. U.S. PAT OFF.

★ WHEN IT'S ALL OVER W-E WILL BE BACK! ★

More About

DEHYDRATION

WHILE there is nothing new in the use of dried foods, for such items as sun-dried meat, fish and fruit formed the diet of the American Indian, the war has aroused new interest in the process of dehydration. Meat and fish, particularly, are receiving careful study, and dehydrated eggs, milk, vegetables and fruits are being produced on a large scale.

Among the authorities speaking on the subject at the recent meeting of the American Dietetic Association was Dr. E. M. Mrak, University of California, who emphasized the fact that fruits may be dried by the sun, by dehydration or by a combination of these two processes. Some of them are steam blanched prior to sulphuring and are dehydrated without exposure to sun; it has been found that by this method the vitamin retention is better and the drying time is shorter.

Blanching Improves Vegetables

Vegetables must be blanched by steam after they are cleaned, sorted and trimmed to inactivate the enzymes and thus prevent undesirable changes in color, odor and texture and also loss of vitamins. The blanching also will make the dehydrated vegetables refresh more rapidly and cook more quickly. Exceptions to the blanching rule are onions, garlic and red peppers.

Eggs are not treated prior to drying. Some authorities believe that preheating prior to spray drying improves the keeping quality of powdered milk. Meat is ground and cooked before drying. Liquids are dried by the spray method and are sold as flakes or powders.

A series of experiments performed cooperatively by the U. S. Bureau of Home Economics, the New York State College of Home Economics and the New York State Agricultural Experimental Station shows the nutritive value of dehydrated vegetables.

According to James C. Moyer, New York State Experimental Station, Geneva, N. Y., the vitamin A, B_1 and C potency of cabbage, beets, rutabagas and potatoes was followed from the fresh state through the processing prior to dehydration and finally dehydration. Representative samples of these dehydrated vegetables were stored at 75°F., 58°F., 33°F. and —40°F. in three types of packages, namely, glass containers, moistureproof cellophane bags and under carbon dioxide in glass containers. After various intervals, the vitamin potency and palatability of the stored samples were determined.

There was no important loss of the precursor of vitamin A, carotene, from the vegetables during dehydration, but its loss was rapid at all storage temperature above —40°F. Storage under carbon dioxide tended to diminish this loss. Some of the thiamin was bleached out during the blanching process prior to dehydration but there was no further loss of this vitamin during blanching and subsequent dehydration. Dried beets contained little vitamin C. However, it must be remembered that the fresh product is low in this vitamin. The original ascorbic acid content of rutabagas was reduced by 85 per cent during the blanching and drying, but the remaining vitamin C was retained at low storage temperatures. The dried cabbage was high in vitamin C and this content was retained better than in any other vegetable during dehydration.

Storage conditions had little effect on the palatability of cooked beets. This was not so with cabbage where all the samples stored at or below 33°F. were equally good, while those stored at higher temperatures had acquired a brownish color and lost flavor. Rutabagas were affected only in color. Higher storage temperatures caused the color to fade.

Quantities of the commercially dehydrated beets, cabbage, potatoes and rutabagas were cooked in family and quantity amounts and certain vitamin losses were determined. The duration of soaking of the dried vegetables in water prior to cooking had little or no effect on the retention of thiamin, which ranged from 75 to 90 per cent. In all vegetables large amounts of cooking water increased the loss of the vitamins studied. By placing the unblanched dried cabbage in boiling water the vitamin C content was better retained than was the case when it was allowed to soak in cold water before being brought to a boil.

Proper Preparation Is Important

The preparation and cooking of dehydrated foods are important. Lt. Matthew E. Highlands, Subsistence Research Laboratory, Chicago, also of the Quartermaster Corps, stated that the Army soon will have a manual for the use of cooks in which special recipes for small and large portions will be included. The fact that hard water may cause toughening of dehydrated products has been considered.

Given proper preparation, dehydrated foods will be used more by the Army; also, as certain ideas become available, they will find ready acceptance by the general public. Dehydrated fruit juices, such as tomato and cranberry juices, are excellent. Prune and apricot powders mixed with a small amount of sugar and water make an acceptable spread to replace jams and jellies. A striking new item is dehydrated baked beans, which require only the addition of boiling water and heat.

Prior to the war, precooked dehydrated potato shreds were already gaining in popularity, especially in the preparation of mashed potatoes. Dehydrated onion and onion powders and garlic powders had a wide acceptance and the use of dehydrated soup mixture was on the increase. Dehydrated apple quarters or nuggets that can be used in the preparation of applesauce or pie probably will be particularly popular. These have proved as edible as when prepared from fresh fruit.

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Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Chicken Noodle Soup	Pork Chops, Applesauce	Creamed Potatoes	Buttered or Glazed Broccoli	Grapefruit Salad	Caramel Upside-Down Pudding, Whipped Cream
2.	Fruit Nectar	Baked Tomatoes	Mashed Potatoes	Carrots	Celery Hearts, Radishes, Ripe Olives	Black Bottom Pie
3.	Vegetable Soup	Liver With Bacon	Escalloped Potatoes	Green Beans	Peach Pickle	Tapioca Meringue Pudding
4.	Cream of Tomato Soup	Stuffed Shoulder of Veal, Pepper Relish Dressing		Mashed Rutabaga	Pear-Ginger Ale Salad	Raspberry Ice
5.	Mixed Fruit Cocktail	Trout, Tartare Sauce	Baked Potatoes	Creamed Corn	Combination Vegetable Salad	Gingerbread, Whipped Cream
6.	Grapefruit Juice	Meat Loaf	Parsley Potatoes	Piquant Beets	Head Lettuce, Roquefort Cheese Dressing	Italian Plum Cobbler, Whipped Cream
7.	Fruit Juice	Chicken à la Maryland	Mashed Potatoes	Green Beans	Orange, Tomato, Cheese Ball, Green Pepper Salad	Peppermint Ice Cream, Brownies
8.	Tomato-Celery Soup	Leg of Lamb, Mint Jelly	Buttered Rice	Spinach With Lemon	Pineapple-Grape Salad	Cream Puffs
9.	Beef Broth	Boiled-Fresh Tongue, Horseradish Sauce	Escalloped Sweet Potatoes and Apples	Peas	Prune and Cream Cheese Salad	Lime Sherbet
10.	Oyster Stew	Meat Pie	Parsley Potatoes	Cauliflower	Red Pickled Pear Salad	Date Surprise, Whipped Cream
11.	Cream of Musbroom Soup	Veal Cutlets	Riced Potatoes	Asparagus	Apple-Date Salad	Cottage Pudding, Orange Sauce
12.	Grapefruit Cocktail	Scallops, Tartare Sauce	Potatoes au Gratin	Stewed Tomatoes	Head Lettuce, Thousand Island Dressing	Pineapple Upside-Down Cake, Whipped Cream
13.	Cream of Pea Soup	Mock Chicken Legs	Mashed Potatoes	Succotash	Mixed Fruit Salad, Celery Seed Dressing	Prune Puffs, Whipped Cream
14.	Corn Chowder	Fried Chicken	Stuffed Baked Potatoes	Asparagus	Cranberry Fruit Salad	Heart Brick Ice Cream
15.	Duchess Soup	Veal Ragout	Buttered Rice	Baked Squash	Tomato and Water Cress Salad	Peach Shortcake, Whipped Cream
16.	Chicken Broth	Sautéed Liver	Pittsburgh Potatoes	Buttered Celery and Carrots	Apple Salad	Baked Custard
17.	Fruit Cup	Broiled Sirloin Steak	Parsley Potatoes	Buttered Parsnips	Head Lettuce, French Dressing	Whipped Apricot Macaroon Gelatin, Whipped Cream
18	Chicken Broth With Barley	Beef Tongue à la Creole	Baked Potatoes	Peas	Peach Pickle	Apple Betty, Lemon Sauce
19.	Vegetable Soup	Baked Trout, Horseradish Sauce	French Fried Potato Chips	Broccoli	Sliced Tomato Salad	Baked Rice Custard With Raisins
20.	Pineapple Juice	Roasted Pork Butts	Mashed Potatoes	Whole Kernel Corn	Crimson Salad	Boston Cream Pie
21.	Consommé	Roast Turkey With Dressing	Parsley Potatoes	Creamed Green Beans With Mushrooms	Celery Hearts, Radishes, Cranberry Jelly	Pineapple Sherbet, Sugar Cookies
22.	Tomato Juice	Swiss Steak	Potatoes	Buttered Beets and Celery	Grapefruit Salad	Hatchet Shaped Cherry Tarts
23.	Consommé	Baked Macaroni and Cheese		Frozen Spinach	Peach Cup Salad	Lemon Snow With Custard
24.	Italian Plum and Lime Juice Cocktail	Swedish Meat Balls	Escalloped Potatoes	Brussels Sprouts	Orange, Apricot, Pineapple, Nut Salad	Chocolate Blancmange, Whipped Cream
25.	Tomato Bouillon	Lamb Chops, Mint Jelly	Potato Croquettes	Vichy Carrots	Green Salad	Ice Cream, Frozen Strawberries
26.	Mixed Fruit Cocktail	Salmon Croquettes, Cucumber Sauce	Baked Potatoes	Spinach	Carrot, Raisin and Celery Salad	Lemon Icebox Pudding
27.	Grapefruit Cocktail	Rolled Rib Roast	Browned Potatoes	Mashed White Turnips	Tomato Salad	Prune Puffs, Whipped Cream
28.	Vegetable Soup	Chicken à la King in Bread Baskets	Candied Sweet Potatoes	Peas	Peach Pickle Gelatine Salad	Pecan Toffee Ice Cream

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Care of the Patient's Skin

The first of several articles that will appear from time to time in various sections of the magazine on different aspects of geriatrics

C. GUY LANE, M.D. and IRVIN H. BLANK

DEPARTMENT OF DERMATOLOGY, HARVARD MEDICAL SCHOOL AND MASSACHUSETTS GENERAL HOSPITAL, BOSTON

WHEN an individual goes to a hospital or has to remain in bed at home because of sickness, several factors that affect his skin must be taken into consideration. The characteristics of the skin itself vary considerably. Some skins are oily, others dry; some are blond, others dark; some are thin, others thick; some people have much hair, others have little; some skins have specific hypersensitivities, or are allergic to certain substances.

The skin may be altered by reason of age or because of the disease or diseases from which the patient suffers. There may be different reactions produced by treatment and by medicines administered by mouth or intravenously.

Friction and pressure on the skin will be altered and provision must be made for cleansing the skin of external soil and secretions. It is this third group of factors that is of particular importance to hospitals.

If the patient is confined to bed in a hospital, well-planned teamwork among hospital authorities, physician and nurses is necessary to provide for the complete cutaneous comfort of the patient and to avoid some of the discomforts and untoward events that occasionally happen. Much more can be done than routine bed baths and a dash of alcohol and powder to the back.

Many conditions are changed when the normal ambulant adult becomes bedridden. There is a marked increase in the pressure and friction on his heels, buttocks, elbows and shoulder blades—areas that are normally subjected to little pressure. Some areas of the skin are kept moist because the bed linens, under some circumstances, become wet with perspiration and remain damp because there is little chance for evaporation. Particularly is this true for the sheet on which the patient lies. The patient's skin is cleansed less efficiently by a bed bath than by a tub bath or a shower.

Each of these conditions contributes to the discomfort of the patient, to changes in his skin and, particularly, to the formation of bedsores.[1] What can be done to control these various factors?

Everyone is agreed that bedsores can usually be prevented by satisfactory nursing care. The nurse who is careful to smooth out the sheets so that there are no rough surfaces to rub on the patient's skin when he moves, who frequently changes the position of the patient who cannot move voluntarily and who carefully cleanses the patient's skin does much toward preventing bedsores.

Unfortunately, all patients do not and cannot receive the best possible nursing care. Particularly in times such as these when so many hospitals are understaffed, the nursing care of patients becomes unavoidably poorer.

If the patient cannot get adequate nursing care, what else can be done to aid in the care of his skin? First, the method of bathing the patient possibly can be changed. Second, it is possible that laundering methods might be altered so that bed linens are smoother and more absorptive and, consequently, less irritating.

Soap is an almost universally used detergent. Each time the patient's skin is washed with soap and water its surface becomes more alkaline than is normally the case. Subsequent to washing the skin slowly recovers its normal acid character (pH 4.5 to 6.0). The more soap left on the skin because of poor rinsing, the longer the skin remains alkalized. Rinsing for the bed bath is necessarily less efficient than for a tub bath or a shower.

All the consequences of alkalization are not yet known. There are probably no harmful effects from mild alkalization if the skin is not alkalized too frequently, but it is known, for instance, that certain fatty acids present in soap are more irritating to the alkalized skin than to the normal acid skin. Under strong alkalization, the skin becomes macerated. This is probably true to a lesser degree for mild alkalization. Marchionini and Schmidt believe that the normal acid surface helps to prevent the invasion of microorganisms into the skin.

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1. B. Fantus, Therapy of Bedsores, J.A.M.A. **104**:46, 1935.

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New detergents have been developed in recent years that are acid (pH 5.0 to 6.5 as compared to 10.5 for soap). Some of these detergents have been used for cleansing the skin and have been shown to be nonirritating and, in fact, can frequently be used satisfactorily by persons whose skins are definitely irritated by soap.

One of these detergents, a mixture of a sulfonated vegetable oil, mineral oil and water, was used as the only detergent in a 19 bed dermatological ward for more than a year. The sulfonated oils do not lather and have not yet been made into a solid cake but they are water miscible. To give a bed bath, some of the sulfonated oii is poured onto a moistened wash cloth, which is then used similarly to a soaped cloth. The oil is subsequently well rinsed off with clean water.

No irritations, which were thought to be due to the detergent, developed on the skins of any of the patients on this ward. There were no bedsores on any of the patients during the year but no claim is made that the absence of bedsores was due to the use of this detergent instead of soap. Actually, bedsores are seldom seen in this ward because there are not many patients who are bedridden for long periods of time and the ward has been adequately staffed with nurses.

No Tests Made on Chronically Ill

So far as we are aware, no clinical test has been made using one of these new detergents in a hospital in which there are many chronically bedridden patients. Not until such a test is made can it be said that the substitution of an acid detergent for soap would help to prevent bedsores or reduce the number of superficial infections of the skin.

With regard to the texture of the bed linens, R. J. M. Love says, "Harsh linen, resulting from overzealous laundering, is a definite contributory cause of bedsores and in some cases the linen is impregnated with chemicals which act as irritants to a susceptible skin."

Many factors in the laundering of bed linens affect the texture of the clean linens, such as hardness of water, use of starch, amount of rinsing, use of an acid rinse to neutralize the residual alkalinity of the soap, method of drying and moisture content when ironed.

Most laundering operations are probably designed to handle the laundry at maximum efficiency and to give the longest possible life to the linens rather than to obtain linens of maximum softness so as not to irritate the patients' skins. Whether softer linens can be obtained with no decrease in the efficiency of the laundry and no decrease in the life of the linens has not yet been established.

Laundry Soaps Seldom Irritating

It is questionable whether a soap or a bleaching agent used in laundering can be left in linens in sufficient concentration to cause a dermatitis. As a rule, rinsing is thorough. Although it is improbable that all the soap can be rinsed from the linens, it is likely that only a little remains afer rinsing. Persons who are known to be irritated from the use of soaps or bleaching agents usually find that they must come in contact with relatively large amounts of these materials before any irritation appears. It is, therefore, unlikely that the small amount of laundering materials left in the linens is of itself responsible for any cutaneous irritations of any sort.

It is probable that in only a few instances do soaps and bleaching agents act as true allergens. Residual calcium soaps, which result when hard water is used, make the linens harsh and rough and may cause mechanical skin irritation.

Detergents other than soap were used for laundering clothes before they were tried for cleansing the skin. We do not know if bed linens, when laundered with such detergents, would be softer and less irritating to the skin than when washed with soap. They would, however, probably be less alkaline than linens washed with soap only.

One method whereby linens can be made definitely softer is by the use of a finishing or softening oil in the final rinse water. These are usually sulfonated oils, similar to the detergents used for skin cleansing. They are known to be nonirritating to the skin. So far as we are aware, the only clinical work that has been done along these lines is some that we have carried on which has not been previously reported.

Sulfonated olive oil was added to the final rinse water in a laundry of a small maternity hospital over a period of about two months and also in a commercial diaper laundry. There was definitely less erythema and chafing on the knees, chins and buttocks of the infants in the hospital when this procedure was used. The diaper laundry found that the washed diapers were much softer when the sulfonated oil was used than they usually were.

The sulfonated oils are good wetting agents and the linens and diapers into which they have been incorporated during the laundering process are subsequently more easily "wet" by water. This means that they will more easily absorb water, sweat and urine.

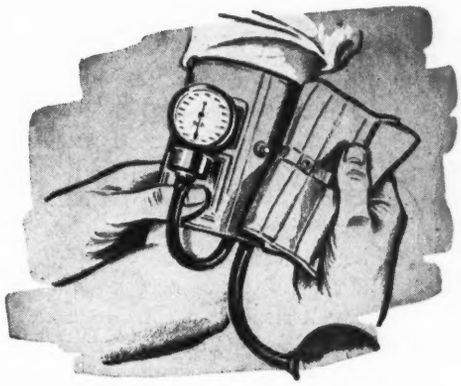
Reduces Dust in Air

It has been stated by van den Ende and Thomas that the treatment of linens with emulsions of sulfonated oils and mineral oils reduces the amount of dust in the air during bedmaking, with a resultant reduction of 99 per cent in the number of viable organisms in the air.

From the point of view of the hospital executive, the major objection to the use of the new detergents for washing the patients or to their use in the laundry is, of course, the increased cost. The new detergents are more expensive than soap; the use of softening oils would increase the materials and labor cost for the laundry and lengthen the time of washing. However, shorter hospitalization for the patients, longer life to the linens and less cost for medicaments for irritated skins might offset this added expense.

No exact records were kept for the experiment carried on at the maternity hospital but it was the impression of the nursing staff that there was an appreciable saving because the medicaments usually used on the infants' skins were not necessary when the softer linens were used.

An experiment over a long period of time with careful controls, preferably in a hospital for chronic diseases, would be necessary before it could be determined whether the use of the new detergents for washing the patients or the use of softening oils in the laundry actually does reduce the time of hospitalization or increase the life of the linens.



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Put Idle Equipment to Work

MANY times have I heard a hospital pharmacist say, "Certainly, I could do that too if I had the equipment, but the board does not want to put the money into this type of equipment. It is expensive and would require two or three years to pay for itself."

It is in such cases that used equipment is particularly valuable. If new equipment can pay for itself in two or three years, used equipment can usually pay off in three or six months. What board would object to paying as much as $200 for any piece of equipment that would return its own cost over such a period and pay a dividend of like amount for several years thereafter?

In looking for new equipment, it might be well to check over little used or unused equipment in the hospital that could be of service.

At the Battle Creek Sanitarium, Battle Creek, Mich., we were exceedingly fortunate in having several pieces of used equipment that were adaptable to pharmaceutical uses. An electric mixer with a 15 gallon bowl was idle, as were two 1 gallon milk pasteurizers, several stainless metal benches and a set of intercommunicating telephones. A two compartment steamer was traded for a used autoclave. Other equipment was made through our own efforts.

Seldom a day passes but some of this equipment is in use, either leaving more free time for the pharmacist or accomplishing savings for the institution.

For some jobs, man hours of labor have been cut from 30 to three per month. In others, a net saving of $71 per hour has been realized for the institution and new services have been performed without increased personnel.

Used equipment might be your way out, too.—GEORGE T. GRIGGS, *chief pharmacist, Battle Creek Sanitarium, Battle Creek, Mich.*

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Sulfa Drugs for the Skin

J. L. Miller's report (Archives of Dermatology and Syphilology for September 1942) on sulfanilamide and its derivatives in ointment form was made because of their increasing use in an ever-widening group of skin conditions. He used sulfanilamide, sulfathiazole, sodium sulfathiazole and sulfadiazine incorporated in bases that were essentially water in oil emulsions and in strengths varying from 5 to 50 per cent. The 115 cases studied fell readily into three major categories: (1) primary infections of the skin; (2) diseases of the skin with secondary pyogenic infections, and (3) miscellaneous diseases.

The results of treatment, however, bore no relation to this classification but were dependent upon whether the infection was superficial or deep. Cure was obtained in all patients with superficial infections—whether the disease was primarily pyogenic, as in the case of impetigo, or secondarily pyogenic, as in the case of allergic eczema or psoriasis. On the other hand, the results were not nearly so good in the deeper seated infections, such as sycosis vulgaris.

Reactions to the ointments were uncommon; they varied from the mild to the severe and occurred only after sulfathiazole ointment had been used in concentrations of 10 per cent or higher. The two severe reactions occurred in patients who had received the 50 per cent concentration; they appeared to be characteristic and lasted, despite treatment, about three weeks.

Of the ointments, sulfanilamide appeared to be as effective as sulfathiazole, even on patients with Staphylococcus aureus infections. The results with sulfadiazine were not nearly as impressive. Sodium sulfathiazole showed no greater efficacy than the others but did show a greater tendency to produce irritation because of its alkalinity.

A 5 per cent sulfanilamide or sulfathiazole ointment is, therefore, recommended.—SIGMUND L. FRIEDMAN, M.D.

Tuberculosis in College Students

Tuberculosis is still first among causes of death in college students. Ten years ago the tuberculosis committee of the American Student Health Association started an antituberculosis program in colleges. This program is discussed in the *American Review of Tuberculosis,* September 1942, in an article by C. E. Lyght.

In 1931, only six institutions had such a program, while in the academic year of 1940-41, 304 institutions, or 36 per cent of all the colleges in the U. S. A., reported such activities. In 1940-41, routine tuberculin tests were done in 255 colleges; 83 per cent of these employed the Mantoux technic. In 1936-37, 27.3 per cent of the tuberculin tests were positive; in 1940-41, 20.7 per cent of all tests were positive. In 1936-37, 20 per cent of the schools that gave tuberculin tests made chest films of all reactors; in 1940-41, the percentage was 28. In 1936, routine chest films without tuberculin testing were taken in 12 per cent of the schools, while in 1940-41 this procedure was done in 16 per cent. In a few colleges mass surveys were performed with miniature films.

Since 1936, 184 new cases (27.5 per hundred thousand) were found among 668,895 students enrolled in colleges without a program of case finding, while 3523 new cases (190.5 per hundred thousand) were discovered among 1,850,755 students enrolled in colleges that have an organized tuberculosis program.—GEORGE C. LEINER, M.D.

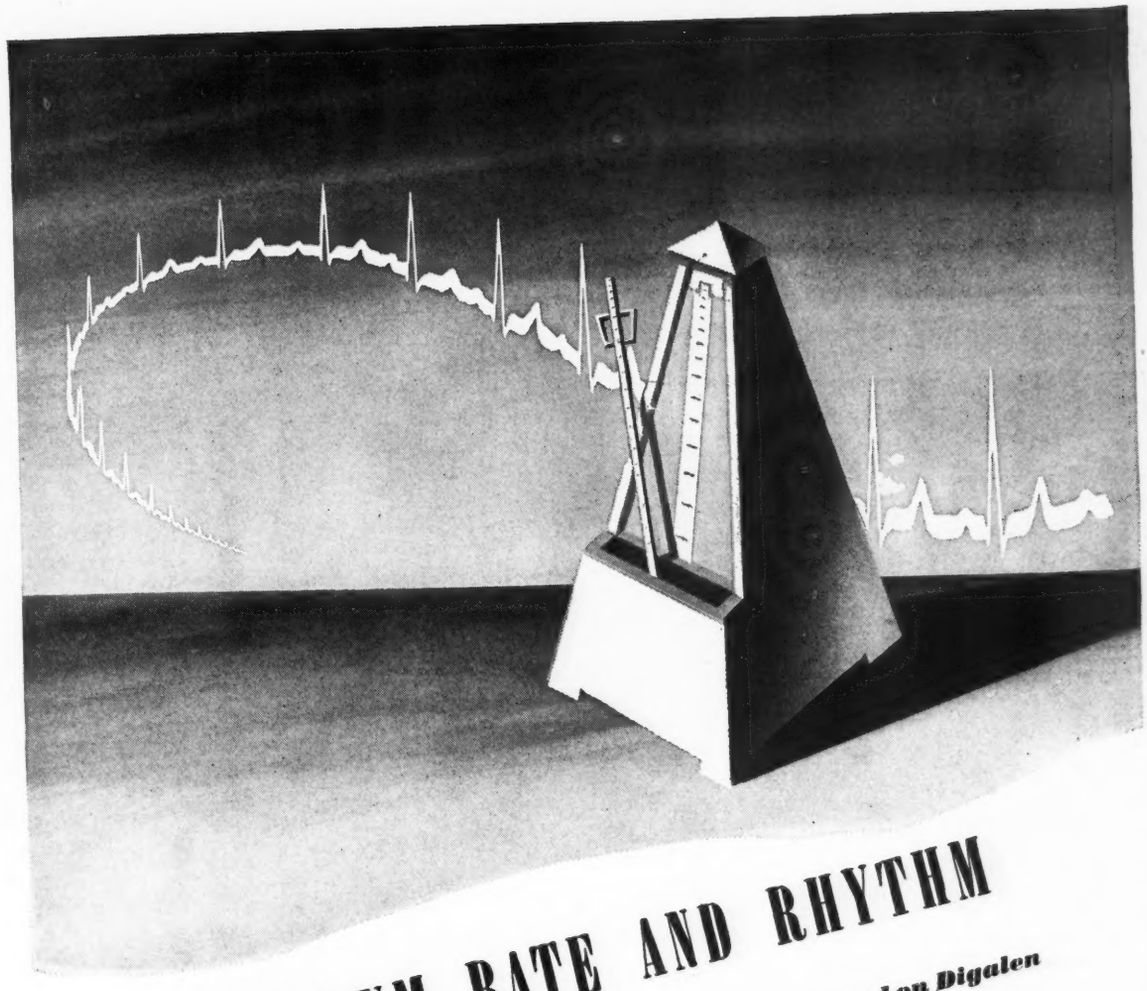
Sawdust Beds and Dressings

The use of sawdust pads as dressings dates back to 1877 when Callender, in reporting on them in the *Lancet* of that year, referred to them as "Surgeon-Major Porter's sawdust pads."

According to an article on "Saving Cotton Wool and Using Sawdust," which appeared in the *British Medical Journal* of July 25, 1942, these pads were recommended by Poore in 1903 to a railway commission for use as urinals because of their deodorizing properties.

The use of the pads as surgical dressings appears to have been neglected till 1914, when Cathcart employed them as dressings for septic and operative cases, shell wounds and for cases of urinary incontinence. His article contains details of the manufacture of the pads. It was this article that Fitzwilliams recalled when he found himself in charge of a 100 bed hospital in Rumania during World War I with only a pocket surgical case and no dressings. As a result of his experience with the sawdust pads, he "came to regard them as almost ideal for simplicity and effectiveness."

Made by sifting the pinewood sawdust through sieves and placing it in muslin bags, these pads were used on all types of wounds, most of which were septic and discharged freely. He found the great advantages of the pads



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to be their deodorizing and highly absorbent qualities and their cheapness.

Fitzwilliams now suggests their renewed use in the British Isles because of the shipping problem that cotton wool, by its mere bulk, will present for the duration. He also urges the conservation of cotton wool in the following ways: (1) using less material to diffuse the pressure of splints applied to obese patients; (2) eliminating it, so far as possible, in simple operative wounds and in the dressing of clean wounds, and (3) replacing it with a soft towel for fomentations.—SIGMUND L. FRIEDMAN, M.D.

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D. Arnold J. Lehman, M.D., and Harold Chase, M.D.

Chemical Warfare Agents

The second large group of war gases includes the nonpersistent agents. Among them we find chloropicrin, phosgene, diphosgene and chlorine. These agents, like mustard gas, lewisite and arsenic-containing sternutators, are irritating in varying degrees, thus producing symptoms and effects commensurate with their irritating properties.

Chloropicrin

This gas is also called "vomiting gas" because of its propensity for causing vomiting, no doubt resulting from gastric irritation incident to swallowing saliva containing the gas rather than from central action upon the vomiting mechanism as is the case with apomorphine. Chloropicrin is more potent than chlorine gas but is less potent than phosgene and diphosgene. Exposure to concentrations of 2 mgm. per liter for ten minutes or to 0.8 mgm. per liter for thirty minutes is fatal. Its odor is described as sweetish, flypaper like, often resembling anise oil.

Physiologic Effects: The gas is a powerful lung irritant and strong lachrymator. It is also a potent emetic and produces diarrhea with colic. However, the chief hazard attends its damaging effect to the entire respiratory system, especially to lung tissue. There are severe pain and spasm of the larynx and bronchial musculature, a burning sensation in the throat with coughing and a sense of suffocation. Labored breathing is inevitable.

High concentrations of chloropicrin may cause sudden death by way of reflex vagal nerve stimulation resulting from irritation by the gas of the trigeminal nerves in nasal mucosa. Since the irritant gas simultaneously inhibits respiration, myocardial arrest is more probable with the accompanying myocardial ischemia and coronary artery constriction. Atropine is the only drug indicated to relieve vagal action in this case but, fortunately, the clinical picture is seldom presented by the gassed patient. Furthermore, time would militate against proper treatment if cardiac syncope were to develop under field conditions.

If the gas gains access to the alveoli, widespread irritation of pulmonary tissue results leading to pulmonary edema or "wet lungs." This results in:

1. Inadequate oxygenation and excretion of carbon dioxide.
2. Right heart failure owing to increased pulmonary resistance.
3. Anhydremia from loss of fluid to alveoli and intestine.
4. Severe acidosis from retention of carbon dioxide.

Early poisoned cases are called "blue cases" but late or severely poisoned subjects in profound shock are known as "gray cases."

Treatment: Absolute rest is mandatory! A physician should be called at once. The eyes should be washed with boric acid solution and comfort from conjunctival pain may be gained from 2 per cent butyn, 2 drops p.r.n. Because of extreme photophobia the patient should be kept in a darkened room with no bandages over the eyes. Periodic steam inhalation through a hose from a croup kettle (cf. Beckman's Therapeutics, Fourth Edition) may offer some relief to the respiratory tract. Cough may be controlled with codeine and systemic comfort gained by judicious use of morphine—judicious because of morphine's propensity for depressing respiration which might be undesirable in a severely gassed patient.

Adequate oxygenation may be gained with the oxygen tent, nasal catheter or, preferably, with the Boothby-Lovelace mask, the advantages of which we have described elsewhere (Emergency Drugs, *J. of Indiana St. Med. Assoc.* **35**:210 April 1942). The patient should be kept warm. Bloodletting to the extent of 400 to 700 cc. has been resorted to in the congested blue cases, but this procedure obviously depends upon nicety of the physician's judgment of the patient's condition.

Never should bloodletting be permitted in gray cases; rather, transfusion with saline is indicated. Saline is distinctly contraindicated, however, in most blue cases as is obvious. Alkalizers may be administered to combat severe acidosis and one may have to consider proper sulfonamide therapy if bronchopneumonia ensues as a sequel to severe pulmonary damage by the gas.

Phosgene and Diphosgene

Phosgene and diphosgene are similar in their actions with the latter somewhat more potent in its damaging effects. Phosgene smells like new-mown hay or, to some, like musty hay or green corn and diphosgene resembles sour ensilage in odor.

Physiologic Effects: These gases are about ten times more toxic than chlorine gas. Exposure for ten minutes to a concentration of 0.5 mgm. per liter is fatal. Like most of the gases discussed in this series, they depend to some extent for their irritant effect upon hydrolysis of the gases to free hydrochloric acid; hence, primary irritation is less severe and delayed pulmonary damage is the chief feature of their poisoning effects. The pulmonary effects may be delayed for an hour or more after exposure, so that close observation of the patient for hours is mandatory.

Treatment: Phosgene and diphosgene cases are given the same treatment as for chloropicrin.

Conclusions

The salient features of mustard gas, lewisite, ethyldichlorarsin, diphenylchlorarsin, diphenylamine chlorarsine (adamsite), chloropicrin, phosgene and diphosgene have been discussed briefly in this and the two preceding articles.

There are others but these are most important. All have multiple actions dependent upon the degree of irritation of different tissues. However, the arsenic-containing agents, *i.e.* lewisite, ethyldichlorarsin, diphenylchlorarsine and adamsite, are two-edged swords in the secondary damage because it is necessary to contend with the arsenic. Early treatment is mandatory but watchful waiting is also indicated when it comes to sustained therapy.

We may never be "gassed" except probably by "token" bombs as a last desperate effort by the enemy, invoked more by anger than hopes of major success. But mortals as we are, as yet incapable of settling our international differences without resorting to mass murder, we would be still more foolhardy to be found unprepared to cope with gas attacks.—FREDERICK F. YONKMAN, M.D.

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NEWS IN REVIEW

WASHINGTON NEWS

Hospitals Will Be Given Fair Share of Rationed Foods, Jones Asserts

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—Claude R. Wickard, secretary of agriculture, has been put in control of production and distribution of food by a presidential order issued December 6. Powers of the W.P.B relating to food go to Mr. Wickard who will appoint a new advisory board. He is to operate civilian rationing through the O.P.A. To help the new food administrator carry out his program, the department's agencies are regrouped into a Food Production Administration and a Food Distribution Administration.

Large quantities of canned citrus fruit and juices are being bought for military use and shipment overseas, but Everett Jones assures hospitals that he will try to get their share for them. The same assurance goes for other canned fruits, canned fruit juices, canned vegetables and vegetable juices. No change has been made in the amount of canned foods that will ultimately be available for civilians, but monthly supplies have been limited by wholesalers to their customers in a monthly quota established November 23 by Conservation Order M-237 as amended.

A critical butter shortage has evoked the temporary Order M-271, issued December 4. It is designed to help relieve during December and January the most critical butter shortage in ten years. A more comprehensive order will follow.

The order means essentially that during December and January commercial manufacture of ice cream, frozen custard, milk sherbet and other frozen desserts and of ice cream mix is reduced by 20 per cent below estimated current winter output. This order applies not only to ice cream plants but also to eating places that make their own ice cream.

Though Order M-259, issued November 25, prohibited dairy producers from distributing whipping cream to hospitals, a revision of the order now permits hospitals to use the heavy cream for certain purposes.

In a recent statement Mr. Jones revealed that roller processed powdered milk is available without restriction, although 90 per cent of the spray processed type is limited to use by the armed forces. He recommended that those who cannot obtain adequate supplies of powdered milk get in touch with Paul Quintus, food control department of the Department of Agriculture, who has given him assurance that hospitals' needs will be met.

Representatives of W.P.B. Government Division Listed

WASHINGTON, D. C.—Hospital administrators are advised to get in touch with their regional representative of the Governmental Division of W.P.B. They would do well to take these men through their hospitals, acquaint them with hospital needs and problems, it is pointed out.

Such friendly contacts might ensure a more sympathetic and responsive hearing when the administrator had need to appeal to the W.P.B. official.

The representatives and their territories are as follows:

E. V. Hickey, 17 Court Street, Boston. (Conn., Me., N. H., R. I., Vt.)

Donald K. Vanneman, 122 E. 42d Street, New York. (N. J. [covers the northern part of N. J. jurisdiction over state requirements in N. J. falls to New York regional office], N. Y.)

Thomas H. Healy, 1617 Pennsylvania Blvd., Philadelphia. (Del., Md., N. J. [covers the southern part of N. J.], Pa. [Covers Eastern Pa. jurisdiction over state requirements in Pa. falls to Philadelphia regional office], Va.)

Frank G. Etheridge, 116 Candler Bldg., Atlanta, Ga. (Ala., Fla., Miss., N. C., S. C., Tenn.)

Fred W. Ramsey, 1300 Union Commerce Bldg., Cleveland. (Ky., Ohio, Pa. [covers Western Pa.], W. Va.)

Arthur C. Meyer, 20 N. Wacker Drive, Chicago. (Ill., Ind., Iowa, Wis.)

George D. Barnett, Mutual Interstate Bldg., Kansas City, Mo. (Ark., Kan., Mo., Neb.)

A. W. Roberts, 910 Fidelity Bldg., Dallas, Tex. (La., Okla., Tex.)

Fred W. Roberts, Kittredge Bldg., Denver. (Colo., Mont., N. M., Utah, Wyo.)

James A. Whiteside, 1355 Market St., San Francisco. (Ariz., Calif., Ida., Nev., Ore., Wash.)

P. C. Duborg, 7310 Woodward Ave., Detroit. (Mich., Ohio.)

Thomas L. Lambert, 334 Midland Bank Bldg., Minneapolis. (Minn., N. D., S. D.)

Filing of Many PD-1A Applications Eliminated by "Distributors' Plan"

WASHINGTON, D. C.—Everett Jones urges hospitals to buy from suppliers who operate under what it known as the "distributors' plan." One of the advantages to be derived from purchasing from such suppliers is that hospitals can eliminate the necessity of filing PD-1A applications for a great majority of the items needed for essential maintenance and repair purposes.

Copper wiring and a few other articles are the only major repair items on which delivery to the ultimate consumer for purposes of maintenance and repair is restricted on the consumer's level by a specific L or M order.

Suppliers and buyers must not confuse the numerous L or M orders that restrict or prohibit production on the producer's level except on high ratings with the relatively small number of such orders restricting or prohibiting the delivery on the consumer's level.

Buyers can obtain brass valves, miscellaneous plumbing, heating and electrical supplies (when these items are in stock and if they are to be used for maintenance and repair) from suppliers who operate under the "distributors' plan," even though such articles contain critical materials, on an A-10 rating under P-100. The supplier will receive the higher rating necessary to replenish his stock for all items sold under this plan on an A-10 rating under P-100.

New Order L-221 Restricts Electric Motors, Generators

WASHINGTON, D. C.—Issued December 2, Order L-221 restricts the acceptance and delivery of orders of electrical motors and generators. Motors having a rating of 1 h.p. or more and generators having a rating of not less than ¾ kw. and not more than 6000 kw. are covered by the order. This does not apply to generators used in the operation of passenger automobiles, trucks and truck trailers as defined in Order L-158. "Special motor" as used in a subparagraph of the order means any motor other than a general purpose, horizontal, continuous duty, open type of 40° C. rise motor.

After the prospective purchaser has convinced the W.P.B. that he cannot find a second-hand motor or generator, he must still prove (1) that the motor or generator does not replace existing equipment (except as otherwise authorized by the Director General for Operations, upon appeal, when copy of authorization is to be attached); (2) that he needs it immediately and not for stand-by purposes, and (3) that the horsepower of the motor is no larger than is needed.

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These Questions Must Be Answered When New Construction Permit Is Sought

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

Everett W. Jones has announced a new list of facts that must be given before a hospital application for new construction, additions or alterations on form PD-200 will be given any consideration whatever. The list published on page 102 of the December issue of The MODERN HOSPITAL applies to hospital equipment. The new list applies to construction.

1. Give description of present hospital facilities: (a) number of nursing units (wards) and number of beds in each unit. Also describe type of service given in each unit, *i.e.* medical, surgical, obstetric, pediatric, communicable disease, neurophysciatric, tuberculosis; (b) number of operating rooms, delivery rooms, and emergency rooms.

2. Give patient days, per cent occupancy, number of surgical procedures and number of deliveries during 1940, 1941 and 1942.

3. Give same information as in 2 for other hospitals in city or local trade area.

4. State whether all possible beds have been added by: (a) doubling up in all private rooms without going below 65 to 75 square feet of floor area per bed; (b) adding all possible additional beds in semiprivate rooms and wards, and (c) using solariums and waiting rooms.

5. Give rated bed capacity as listed in 1941 American Hospital Association hospital census.

6. Give number of beds now counted as available for use.

7. Give population increase in your normal trade area between Jan. 1, 1940, and present.

8. Give estimated population increase by end of 1943.

9. State whether you have a nursing school and, if so, give average number of students (probationary, as well as all others) in training in 1941 and the number in training at present.

10. Give number of laboratories and type of each.

11. State whether hospital has an out-patient clinic department. If so, give brief description of types of service and space used by clinics. Also, give average daily number of visits (old patients plus new patients) in 1940 and to date this year.

12. Give average length of stay by years for 1940, 1941, and 1942 for: medical, surgical and obstetrical cases.

13. State whether there is a centralized supply and sterilizing room for the entire hospital and centralized or decentralized food tray service.

14. Give complete description of new facilities requested, including same information asked for in question 1a and 1b.

15. State whether enough graduate and student nurses and other types of personnel can be obtained to make effective use of the new facilities.

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Two Construction Limitation Orders Are Interpreted

WASHINGTON, D. C.—Because of some confusion arising from the effect of limitation orders L-41 and L-41-b on certain classes of building materials, clarifying interpretations have been issued to both orders. The materials involved are floor coverings, such as asphalt tile, linoleum tile, cork tile, rubber tile, linoleum and roofing or siding materials. According to the interpretation, when a floor covering, such as linoleum, is made a part of a structure by being cemented in place or in any way affixed to a permanent structure while building operations are in progress, the use is considered to be "construction" whether in new construction, remodeling or rehabilitation.

This same interpretation applies in the case of siding or roofing. The only permissible exceptions are those cases in which patching or replacement takes place solely to mend or restore portions of a structure that have suffered damage or deterioration from ordinary wear and tear, or breakage.

When siding or roofing is applied to an entire wall or an entire roof for the purpose of improving the appearance, the alteration would be classified as construction and would be subject to the limitations of L-41. If the new siding or new roofing is applied to a portion of a wall or roof, not in actual need of repair, it is still counted as construction. Exceptions allowed for "insulation materials" as used in L-41-b do not apply.

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The doctor I work for is one of the busiest pediatricians in town.

When I started working for him, I noticed that he was prescribing plain cow's milk modified—almost as routine. Once in a while when he had a problem case—he would look to S-M-A as his trouble-shooter.

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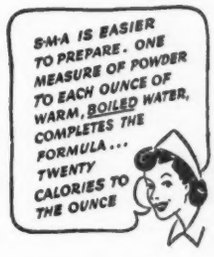
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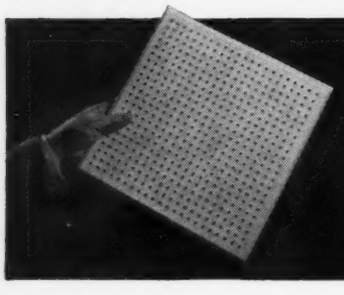

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Critical Appraisal of Interns and Residents Declared Necessary

WASHINGTON, D. C.—The Procurement and Assignment Service declared on December 11 that the expansion of the Army and Navy in 1943 and 1944 will demand the services of such large numbers of young physicians that a new critical appraisal of all positions held by interns, residents and fellows is necessary. New plans for medical and premedical students were announced on December 17.

Medical school graduates who hold commissions in the Army or Navy will be allowed twelve months' deferment of active duty for the completion of an internship. Medical school graduates who are deferred by Selective Service may have their deferments continued through one year of internship.

Medical school graduates who are not subject to induction or likely to be reclassified by Selective Service are not officially restricted as to the length of internships they may serve. However, they have a moral responsibility to make themselves available as early as possible for civilian services.

Those who have already served a year of internship must be considered as residents for the duration of the war.

The minimum number of residencies with which each hospital can function must be determined and residents should then be selected from the following groups in order: (1) physicians who for physical or other reasons cannot qualify for military service; (2) present interns or residents who are deferred by the Selective Service (preference should be given to those in class 4F and class 3A or 3B who maintain a bona fide family relationship with wife or children); (3) present interns who hold commissions in the Army or Navy. No requests for deferment of individuals in this class should be made until the possibilities of filling minimum essential residencies from individuals in groups 1 and 2 have been exhausted.

It is impossible to give assurance that interns who hold commissions will be deferred. If necessary to request their deferment, such requests should be submitted to the state committee of the Procurement and Assignment Service. Approval of these requests must be concurred in by the chairman of the corps area committee and the representatives of the hospital and medical education committees.

On December 17 the Army and Navy announced a college training program which stated that medical students in the enlisted reserve will be called to active duty at the end of the current academic year and will be detailed to continue courses of medical instruction un-

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[1]Robbins, Benj. H., Cyclopropane Anesthesia, The Williams & Wilkins Co., Baltimore, 1940.
*Cyclopropane (Mallinckrodt) may also be obtained through the various offices of the Puritan Compressed Gas Corporation of Kansas City.

75 YEARS OF SERVICE TO CHEMICAL USERS

der contracts to be made by the War Department. Medical students who have been commissioned in the M.A.C. may resign such commissions, enlist as privates and be detailed in the same manner as medical students in the enlisted reserve.

Premedical students in the enlisted reserve corps or inducted before June 30, who take approved courses will continue in an inactive status until the end of this academic year and will then be called to active duty. Those selected for further medical or premedical training will be detailed for such instruction under the Army specialized training program.

Hospitals Still Included in Wage Order; W.M.C. Offers Aid in Finding Personnel

WASHINGTON, D. C.—Although hospitals, as a part of health and welfare services, are included in a list of 35 industries that have been designated as "essential activties" by the War Manpower Commission no provision apparently has yet been made by the War Labor Board or the Commissioner of Internal Revenue to grant exemptions to hospitals from the provisions of Executive Order 9250, the wage and salary "freeze" order.

The Chicago Hospital Council late in November urged a blanket exemption for nonprofit hospitals on the grounds that the order is designed for industrial application and does not fit hospital needs. Furthermore, the personnel shortage in hospitals is rapidly approaching a crisis.

In announcing that health and welfare services were essential, the War Manpower Commission directed hospitals to prepare a list of essential jobs and then to prepare withdrawal and replacement schedules. The essential jobs can be separated from others by answering affirmatively the following questions: (1) Is a training period of at least six months necessary before an untrained worker can attain reasonable efficiency in the job? (2) Is the job essential to the industry? (3) Is the worker irreplaceable?

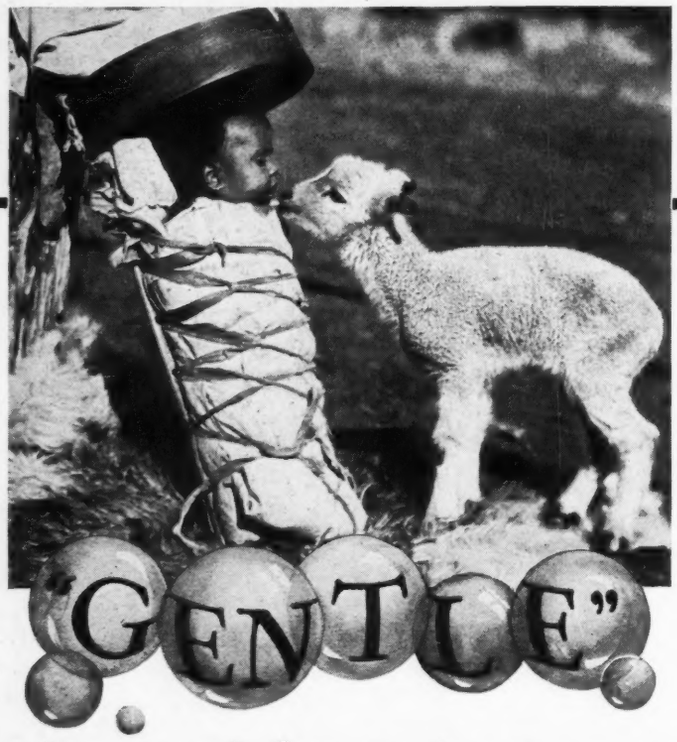
Local Selective Service boards can use these lists to check against any request by an employer for deferment of a worker, pending completion of the withdrawal and replacement schedules. Such deferments, usually granted for a six months' period, do not mean exemption from the draft.

The manning table gives a full story regarding the present employes and the possibilities of replacing those of draft age. After this table is prepared, the employer will draw up a replacement schedule to guide him in upgrading, promoting and recruiting replacements for workers which the compiled information shows him will soon be inducted.

When this schedule has been accepted by the state director of Selective Service, the employer can use a state acceptance number on form 42-A for requesting occupational deferment for unmarried employes liable for military service. This system will enable each employer to know how many employes will be withdrawn from each department and approximately when.

The War Manpower Commission asserts that it will assist employers in every way possible to make replacements and will aid in locating women, older workers and handicapped workers. It will also aid in the training and upgrading programs, although word from the Training-Within-Industry branch of W.M.C. indicates some doubt as to whether that program will be available to hospitals.

The salary stabilization unit of the Bureau of Internal Revenue has issued a form (SSU-1) for employers to use in applying for approval of a salary adjustment for those persons earning over $5000 or those classed as executive, administrative or professional. The last



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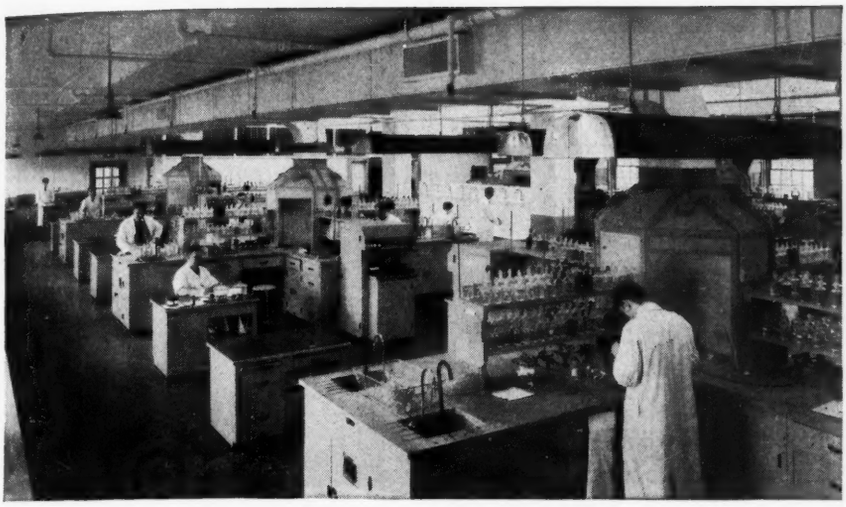


WHAT MERCK *Laboratory Control* MEANS TO THE PHYSICIAN

For many years, physicians have recognized the high quality of Merck Prescription Chemicals, and have demonstrated their confidence and satisfaction by continuous specification of the Merck brand. One of the important reasons for this specification is that the purity and uniformity of these fine chemicals are ensured by rigid laboratory control.

Scores of skilled chemists and technicians, working in spacious and modern analytical laboratories, exercise a constant control over the quality of more than 1,500 drugs and chemicals bearing the Merck label. Scores of tests are necessary to meet the standards which have been established for every product—tests for the quality of raw materials—a series of control tests throughout each step of the manufacturing process—finally, the exacting tests of the finished product before it is released for sale.

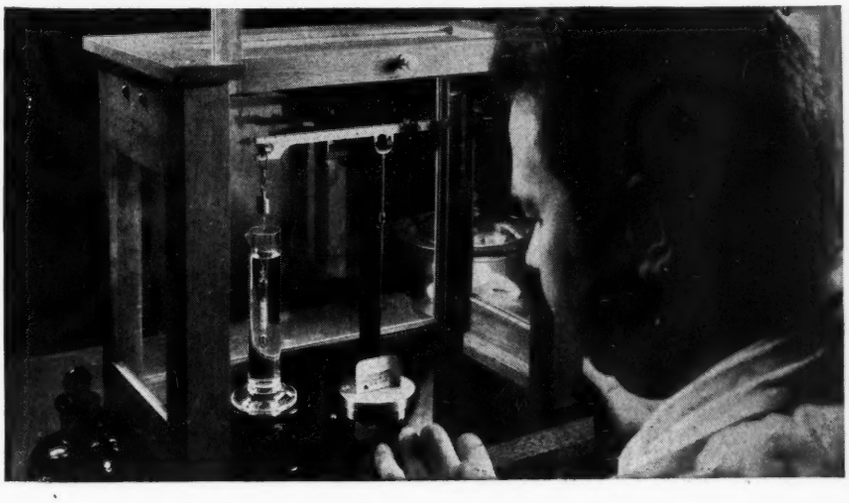
Because of these modern control facilities, the physician who specifies Merck can do so with complete confidence in the purity and reliability of Merck Prescription Chemicals.

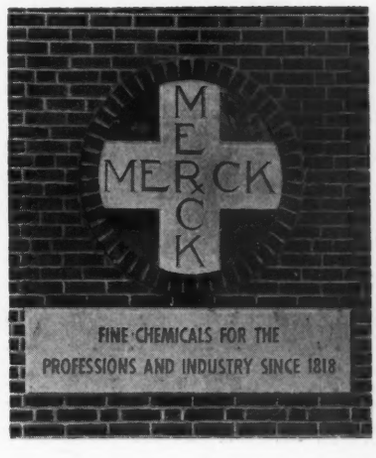
FOR VICTORY — Buy War Savings Bonds and Stamps

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

NEW YORK · PHILADELPHIA · ST. LOUIS · *In Canada:* MERCK & CO. Limited, Montreal and Toronto

Photographs taken in the Merck Analytical Laboratory at Rahway, N. J.





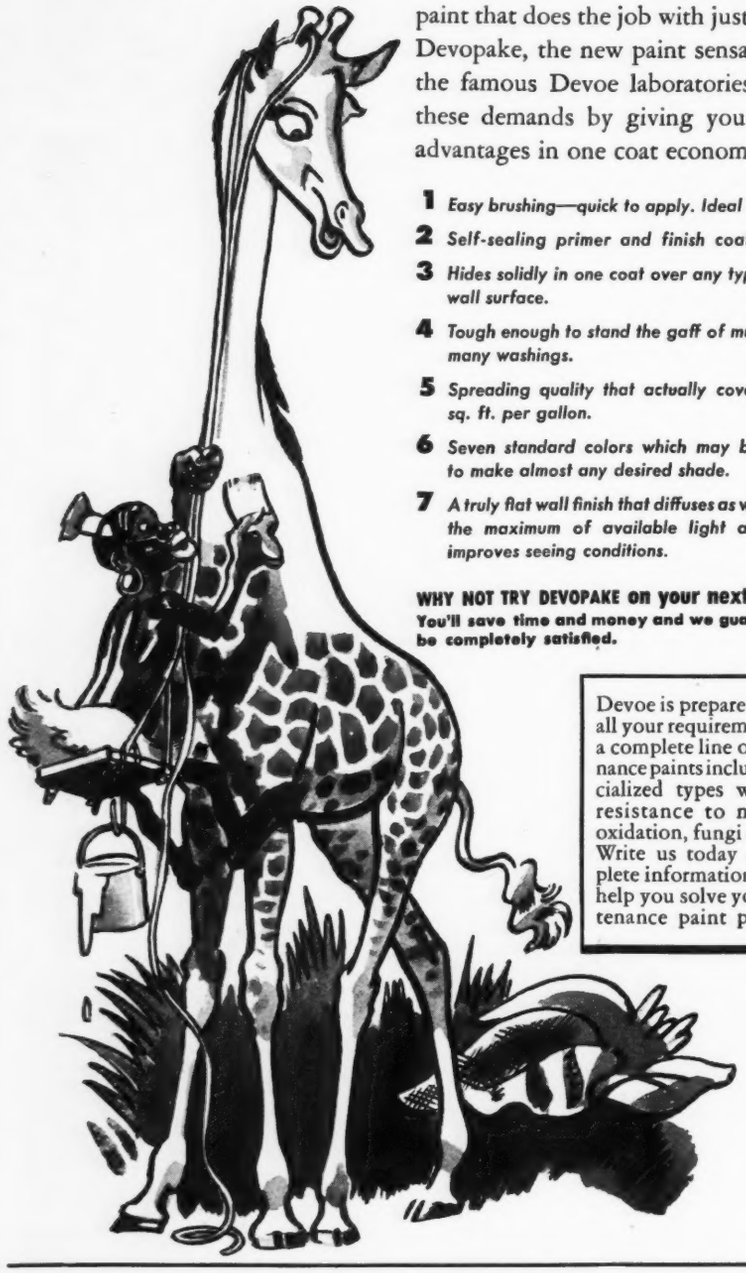
Astonishing!

HOW DEVOPAKE HIDES AND COVERS ANY SURFACE

"MAINTENANCE"—the watch-word for today when critical materials are scarce and minimum interruptions essential—demands a durable, easy-to-apply wall paint that does the job with just one coat. Devopake, the new paint sensation from the famous Devoe laboratories, answers these demands by giving you *all* these advantages in one coat economy:

1. *Easy brushing—quick to apply. Ideal for spraying.*
2. *Self-sealing primer and finish coat all in one.*
3. *Hides solidly in one coat over any type of interior wall surface.*
4. *Tough enough to stand the gaff of much wear and many washings.*
5. *Spreading quality that actually covers 650-750 sq. ft. per gallon.*
6. *Seven standard colors which may be intermixed to make almost any desired shade.*
7. *A truly flat wall finish that diffuses as well as reflects the maximum of available light and therefore improves seeing conditions.*

WHY NOT TRY DEVOPAKE on your next paint job?
You'll save time and money and we guarantee you'll be completely satisfied.



Devoe is prepared to meet all your requirements with a complete line of maintenance paints including specialized types with high resistance to moisture, oxidation, fungi or fumes. Write us today for complete information that can help you solve your maintenance paint problems.

DEVOE & RAYNOLDS CO., INC.

The 189th Year of the Oldest Paint Maker in America

FIRST AVENUE AT 44TH STREET, NEW YORK, N. Y.

groups include nurses, social workers and those with similar duties. The application requires detailed information about the employe's salary and duties. The motive behind the proposed increase or decrease will be the prime consideration of the government in deciding whether to allow it.

A promise made by an employer to his employes prior to October 3 that salaries would be increased in the future is generally ignored. An increase of salaries below $5000 may be approved, however, if to deny such increase would force the continuation of a salary below the general level existing for the same or comparable work in the area on September 15.

As regards wages, the War Labor Board is likely to agree that a maladjustment or inequality exists if the employes in a specific group have had their salaries increased less than 15 per cent since Jan. 1, 1941. No interpretation of the clause about "elimination of substandards of living" has yet been made by the board.

In comparing wages to show that they are below standard, hospitals can compare with other types of organizations in the community, *e.g.*, hotels, restaurants, stores and offices, and also with other hospitals.

Hospitals now paying employes partly in cash and partly in perquisites cannot convert to the full cash basis without approval of the appropriate agency.

A-2 Rating Has Been Granted Hospital Clothing Textiles

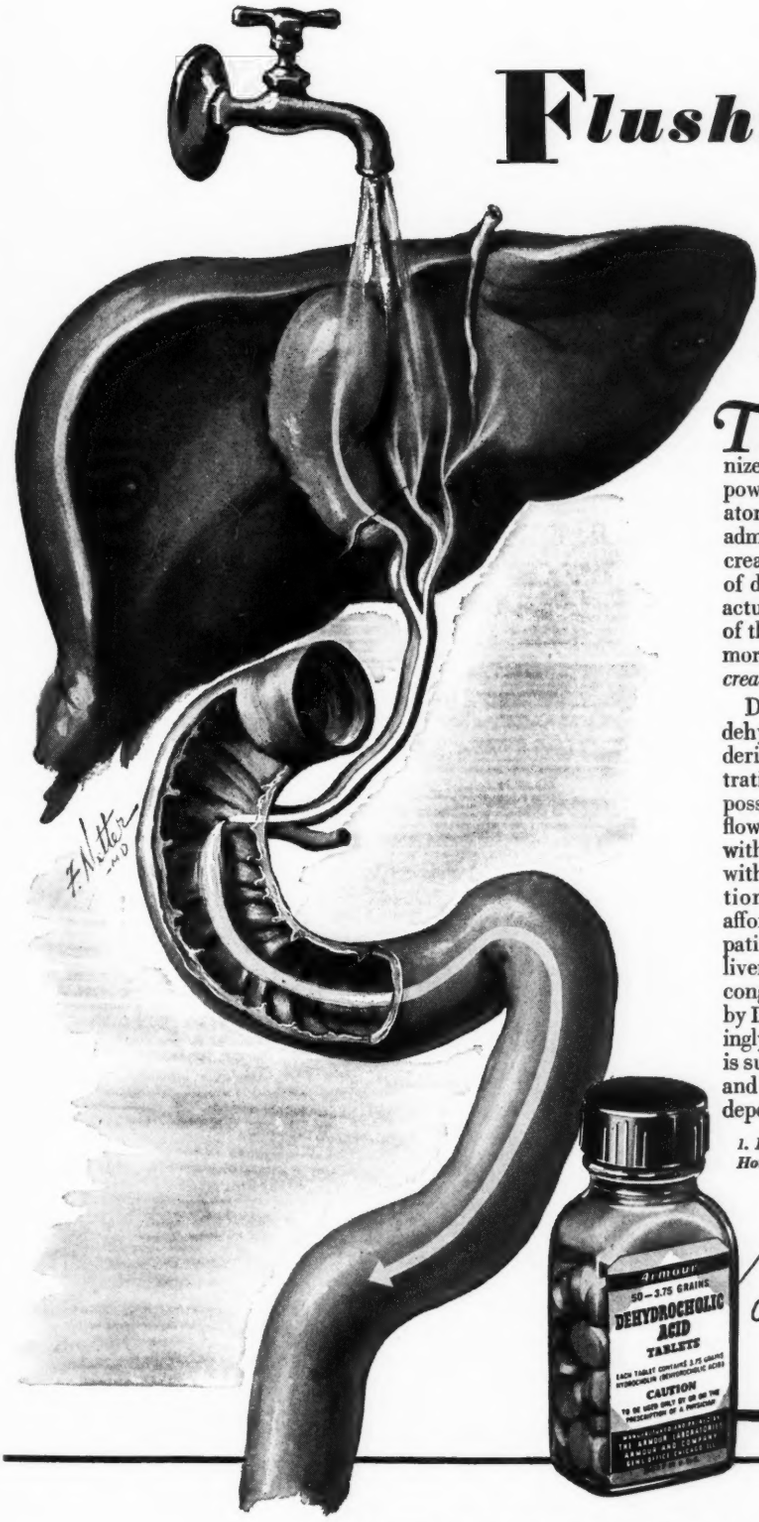
WASHINGTON, D. C.—The A-2 rating on cotton textiles for hospital garments promised by Everett W. Jones has been obtained. On November 21 W.P.B. issued Schedule 3 to Order M-207, assigning an A-2 rating for purchase of specified fabrics used in the manufacture of hospital clothing. This includes uniforms for nurses and other hospital personnel and patients' garments.

The type of textiles for which the A-2 rating is assigned includes cordage sheeting, carded print cloth, carded drills, carded jeans, carded or combed poplins, carded or combed broadcloths, carded colored chambrays, carded seersuckers and carded frock cloth.

Another order is being worked out to provide for all types of hospital linens, Mr. Jones announced recently.

Nurses' Pay Raise Approved

Legislation increasing the pay of nurses attached to the armed forces was sent to the White House on December 14 with House acceptance of Senate amendments. The bill gives all nurses in the service a base income corresponding to that of an ensign in the Navy and a second lieutenant in the Army.



Flushing Out the BILE PASSAGES

THE bile acids (Taurocholic acid and Glycocholic acid) and their sodium salts are recognized pharmacologically as being among the most powerful known choleretics. Ivy and his collaborators (1), however, have pointed out that while administration of the natural acids or salts increases the flow of bile, it also increases the output of dissolved solids so that the viscosity of the bile actually becomes greater. The oxidized or keto form of these acids, on the other hand, produces an even more profuse biliary flow but simultaneously *increases its fluidity*.

DEHYDROCHOLIC ACID, ARMOUR is crystalline dehydrocholic acid—the oxidized form of cholic acid derived from the natural bile. Thus by administration of DEHYDROCHOLIC ACID it is actually possible to "flush out" the biliary passages with a flow of low viscosity bile. In cases of biliary stasis without obstruction and in cholecystitis with or without stones provided there is no actual obstruction of the ducts, such a "flushing out" may afford considerable relief to the patient. In constipation associated with deficient bile secretion, in liver poisoning, in cirrhosis and in chronic passive congestion, the increased flow of fluid bile induced by DEHYDROCHOLIC ACID may also prove exceedingly beneficial.... DEHYDROCHOLIC ACID, Armour, is supplied in 3¾ grain tablets; in bottles of 50, 100, and 500. *Dosage:* one to three tablets at mealtime depending on the individual case.

1. Berman, A. L.: Snapp, E.; Ivy, A. C.; Atkinson, A. J.; and Houch, U. S.: Am. J. Digest. Dis.; Vol. VII; No 8; pp. 336-346.

℞ Dehydrocholic Acid Armour

Have confidence in the preparation you prescribe . . . Specify

Dehydrocholic Acid, *Armour*

THE *Armour* LABORATORIES, CHICAGO, ILLINOIS

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN

New Plans for Accelerating Nurses' Training Offered by O.D.H.W.S.

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—New suggestions for the acceleration of the nurses' training program were prepared and distributed by the subcommittees on nursing and hospitals of the health and medical committee of the O.D.H.W.S. last month.

These changes in the previous recommendations of the National League of Nursing Education were made because of the critical situation in nursing. Schools were urged to put them into effect for students now in school, as well as for those entering later.

One of the principal suggestions is that the proposed twenty-four month program, originally limited by the league to mature college graduates, should now be used for less well-prepared students also. The twenty-eight and thirty month programs are also recommended, the length of time to be determined on the basis of the student's previous educational preparation and her level of achievement in the school.

For each of these accelerated programs, the remainder of the thirty-six months might be used for supervised practice in hospitals. The health and medical committee has given its support to the idea of paying the students during this period of supervised practice at the rate of three fourths of the minimum salary paid to graduate nurses. This is a considerable modification of the proposal by Doctor Baehr that nurses be paid at a rate of $1400 per year.

Another new recommendation is that some schools should effect affiliations with military hospitals to give students their six months of training in such institutions under continued supervision. A third new feature is that, if the need becomes more acute, students might be released from training entirely at the end of the thirty month period to go into military service.

Another proposal put forward by the health and medical committee is called "a temporary emergency plan for nursing education." It proposes that the undergraduate nursing program be divided into (a) twenty-four months of residence in dormitories with training in all basic clinical services and theory being completed during this period and with emphasis upon essential subjects only, and (b) twelve months during which the student nurse will live outside the hospital but continue to serve in an apprenticeship capacity either in the parent hospital or in an affiliated institution.

For such an arrangement, a salary "at the minimum rate for civil service employes, such as stenographers, namely $1440 a year," is recommended. From this amount appropriate deductions should be permissible for food, laundry and other equivalents. This is Dr. George Baehr's plan.

Since any of these plans would require considerably more money than has been available in the past, Dr. Thomas Parran, surgeon general of the U.S.P.H.S., on December 15 was reported to have asked for an increase in the federal allotment for nursing education from $3,500,000 to $5,000,000.

Another proposal, which is being widely discussed by various hospital administrators and educators but has not yet been formally adopted by any official committee, is to transfer all, or a large part, of the formal academic training of student nurses to colleges and univer-

ATTENTION—NURSES

The survey of nurse power being conducted by the U. S. Public Health Service is of utmost importance to the nation's war effort. Please fill out and return your postcard questionnaire fully and promptly.

Protection . . . . . strong and safe and sure as a mother's arms

REFUGE FROM COLIC and hunger and unknown things . . . . . haven later for a tousle-headed tad who's skinned his knee . . . . . comfort for a bruised spirit or a restless conscience . . . . . oracle for school-kid problems . . . . . that's what mothers' arms (and minds and hearts) are for . . . . . .

But even *they* could *not* protect against the tangled legal threads of lost identity . . . . . could *not* prove finally her own son's birthright . . . . . .

You could. You could give life-*long* protection . . . . . could give sure, unquestioned *proof* . . . . . if your maternity routine includes HOLLISTER copyrighted BIRTH CERTIFICATES . . . . . made expressly for *you* . . . . . telling the *authoritative* story of each baby's birth and parentage.

Hollister certificates . . . . . lithographed with dignity and taste to make a superintendent proud to sign his name . . . on good, strong, all-rag parchment to *stay* strong and useful for a lifetime and beyond . . . . to be the constant protection *you* could give to each new life you help to start.

We'd send samples if you'd ask.

FRANKLIN C. *hollister* COMPANY

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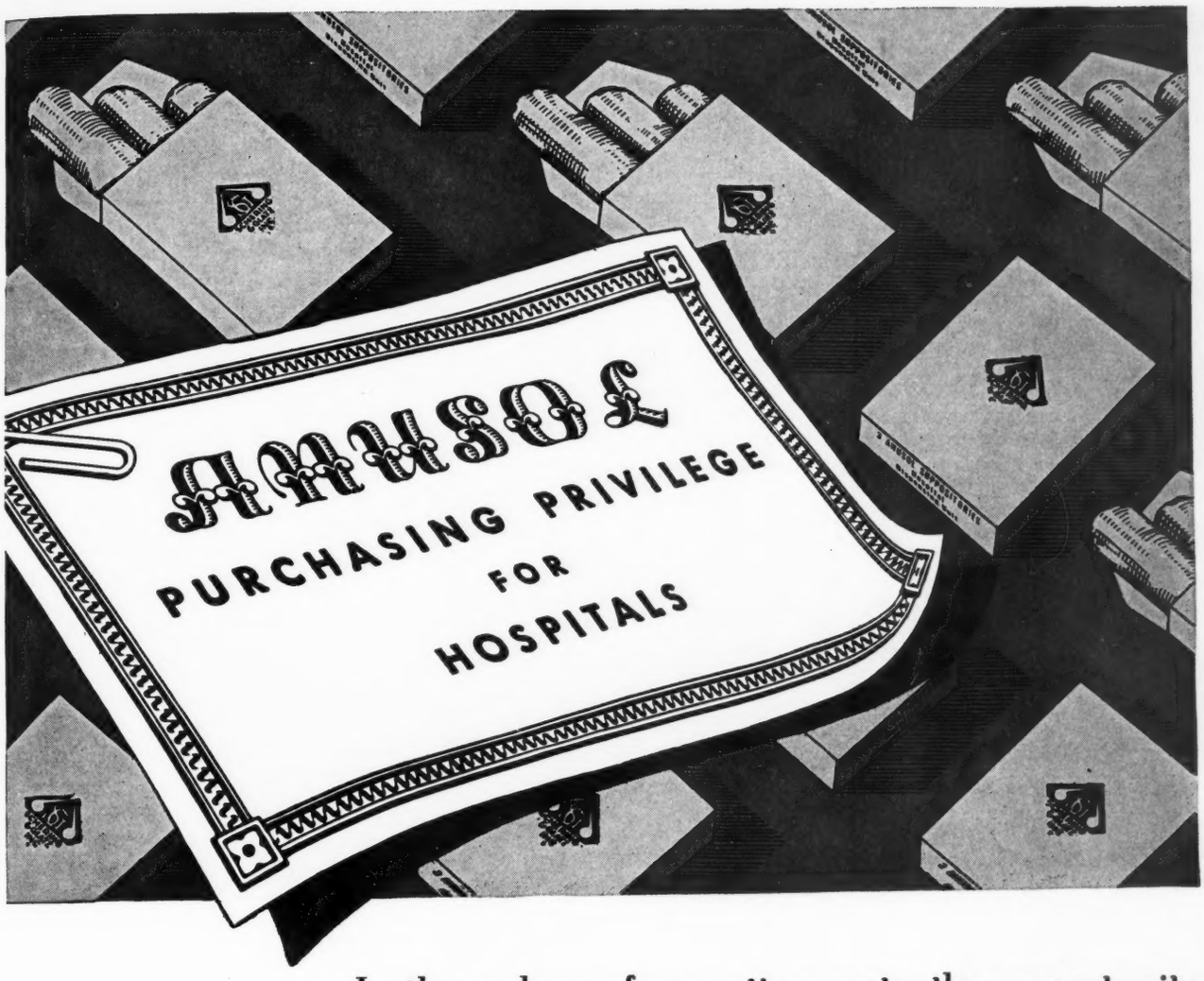

In these days of mounting costs, the opportunity to buy an item at "bargain price" is doubly welcome, especially so if the offer concerns a professionally favored product such as Anusol Hemorrhoidal Suppositories. Each Hospital Package of Anusol, containing eight dozen (96) suppositories, is priced at $4.00 net. A unique feature of this package is its subdivision into 32 individual cartons, each carton containing three suppositories, with space for directions on the cover, and convenient for dispensing.

This economical offer should bring Anusol Suppositories within the budget of all hospitals. The package can be supplied only to hospitals and institutions on direct order . . . the low price permitting no discount. Write for our Hospital Price List showing all the Schering & Glatz products available to hospitals.

SCHERING & GLATZ, INC., 113 West Eighteenth Street, New York

sities. The students would then come into the hospitals for practical experience either on a full-time basis at the completion of the didactic work or for four hours per day on staggered shifts while carrying approximately eight hours of study in college.

This suggestion was presented to a recent meeting of college deans at Northwestern University by Dr. Roger W. DeBusk of Evanston Hospital and has been presented also through official channels by Dr. R. C. Buerki.

Both the federal government and private agencies are providing funds to permit any qualified girl to enter nursing.

Gypsum Is Recommended as Substitute for Metal, Lumber

WASHINGTON, D. C.—In the search for noncritical materials as substitutes for metal and lumber, John L. Haynes, director of the Building Materials Division, W.P.B., points out, any number of uses can be made of ordinary gypsum.

In Utah, government engineers have approved the installation on one large military project of 7,000,000 square feet of laminated gypsum board in roof construction. The material specified is a three-ply lamination fabricated from ½ inch gypsum board of ordinary commercial grade. Roof decks authorized by Navy engineers have been built of poured gypsum. Roofs constructed of laminated gypsum board are an innovation in the engineering and construction fields. In this method, as in the poured-roof construction, the gypsum adequately performs structural functions that are ordinarily served by metal and lumber elements.

Gypsum materials are manufactured in two-ply, three-ply and four-ply laminations of various lengths and widths, generally using ½ inch mill stock. However, laminations can be fabricated from stock of any desired thickness. The Buildings Materials Branch through its gypsum roofing and insulation products section is assembling technical data that will be placed at the disposal of engineers, builders and other persons who may want this detailed information. Inquiries should be directed to Edwin M. Lurie, chief of the section.

WAY BACK WHEN
—gas street lamps and this "copper's" natty attire were the last word, U. S. Slicers led as they lead today... Since originating the first slicer, U. S. has always offered added features, better performance, top quality. When peace again permits production of slicers, we assure you the *New* U. S. will be the slicer you'll prefer! U. S. Slicing Machine Company, LaPorte, Indiana.
U S SLICERS
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WORLD'S BEST SLICERS SINCE 1898

Requirements Questionnaire of A.H.A. Held Important

WASHINGTON, D. C.—Under the Controlled Materials Plan, W.P.B. will bring about the adjustment of production programs to conform to the supply of materials and will allot certain materials to different government entities representing all military and civilian requirements.

In each division of W.P.B. there is to be a subrequirements committee to assemble from the several claimant agencies as complete a statement as possible of their requirements for the materials or products that fall within the division's jurisdiction.

In connection with this procedure the questionnaire on hospital needs sent out some time ago by the A.H.A. for Everett W. Jones is of fundamental importance. The information sought is essential in presenting hospital requirements under the Controlled Materials Plan. Requirements and available supply are ultimately weighed and reconciled before programs can be put into effect.

Hand Service Tools Restricted

WASHINGTON, D. C.—Hand service tools, sales and deliveries of which are limited to purchase orders rated A-9 or higher under General Preference Order E-6, as amended, have been more strictly defined under Amendment 3. As enumerated in the amendment, the tools now covered by the order are metal working chisels, metal cutting files, machinist's ball peen hammers, metal cutting snips and shears, pliers of all types, metal working punches, screw drivers and wrenches of all types.

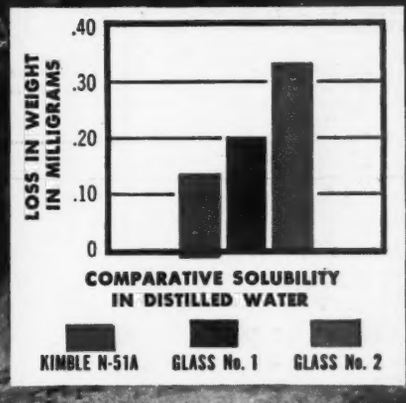
LITTLE DROPS OF WATER, LITTLE GRAINS OF SAND

Little drops of water, in the course of time, turn huge rocks into little grains of sand.

The process doesn't stop there. On the little grains of sand, even after conversion into glass, the little drops of water still have a dissolving effect.

Kimble NEUTRAGLAS (N51A Glass) resists to the highest degree the dissolving effect of distilled water and other chemical attack.

Protect your pharmaceuticals and biologicals to the utmost against deterioration and loss of quality. Standardize NOW on Kimble Ampuls, Serum Vials, Serum Bottles and Clinical Glass Containers made of NEUTRAGLAS (N51A Glass).



ACTUAL PHOTOGRAPH OF SAND TRAIL TO ACOMA, NEW MEXICO

• • • *The Visible Guarantee of Invisible Quality* • • •

KIMBLE GLASS COMPANY . . . . VINELAND, N. J.

NEW YORK • CHICAGO • PHILADELPHIA • DETROIT • BOSTON • INDIANAPOLIS • SAN FRANCISCO

Reference List of Official Orders

(Issued from November 15 to December 15)

Butter.—Order M-267, issued November 21, temporarily froze half the supply of cold storage butter in the 35 principal markets of the U. S. to assure an adequate supply for the armed forces and Lend-Lease during the current seasonally low production period.

Cream, Whipping.—Order M-259, issued November 25, prohibits dairy producers from distributing whipping or other heavy cream to household consumers, retailers, restaurants, institutions and others. Coffee cream is not affected. The order, as amended December 9, now permits hospitals and other medical institutions to obtain heavy cream.

Electric Fan Kits.—Order L-176 made it clear in Interpretation 1, announced November 23, that the sale of parts for portable electric fans in kits or other form is a violation.

Laboratory Equipment.—Order L-144, issued December 5, places additional control over the purchase of laboratory equipment. Authorization for purchase of laboratory equipment valued at more than $50 is required.

Morphine Hypodermics.—Table 1 of Order M-115 by Amendment 2, issued November 24, frees morphine hypodermics from tin restrictions.

Pens, Pencils.—Order L-227, issued December 7, cut production of pens and pencils and at the same time banned the use of critical materials wherever possible in their manufacture.

Portable Lamps.—Order L-33, as amended December 12, prohibits the production, effective immediately, of portable electric lamps and shades containing critical materials.

Sulfamic Acids.—Order M-242, as amended December 12, makes available small amounts of sulfamic acid and sulfamic acid derivatives to various laboratories without application to W.P.B.

Textiles.—Schedule 3, released November 21, to Order M-207 assigns an A-2 rating for purchase of specified fabrics used in the manufacture of hospital clothing.

Vacuum Cleaner Attachments.—Order L-18-b, as amended November 27, prohibits production of attachments for domestic vacuum cleaners.

Vacuum Cleaners.—Order L-18-c, as amended November 21, released for sale to consumers new vacuum cleaners frozen in the hands of dealers since October 24.

Water Heaters.—Schedule 3, issued November 21, to Order L-124, prohibits the use of copper, copper base alloys or tin in tubing or tube sheets for feed water heaters. Seamless steel tubing is also prohibited.

Appearance
Another Measure of an Efficient Product
Indicative of the care taken in the preparation of "Puritan Maid" gases is the outstanding APPEARANCE of the Puritan Cylinder. Identification of different gases is emphasized by attractive and distinctive colors covering the entire cylinder. These colors were adopted in 1927 on the recommendations of the National and International Anesthesia Research Societies and now conform to those approved by the National Bureau of Standards. This offers the finest medical gas for use in hospitals—or doctors' offices—in a container embodying the convenience, safety and appearance expected and needed.
PURITAN MAID
GASES
"Buy With Confidence"
PURITAN
COMPRESSED GAS CORPORATION
BALTIMORE BOSTON CHICAGO ST. PAUL DETROIT
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PURITAN DEALERS IN MOST PRINCIPAL CITIES
PURITAN MAID
TRADE MARK REG.
"PURITAN MAID" ANESTHETIC, RESUSCITATING GASES AND GAS THERAPY EQUIPMENT

Procedure for Obtaining New Mechanical Refrigerators

WASHINGTON, D. C.—The procedure for processing applications from hospitals on PD-427 for authorization to purchase new domestic mechanical refrigerators has been revised and applications now clear through the hospital branch of the Governmental Division.

The PD-427 form must be prepared in triplicate and two copies are to be mailed to the Governmental Division. In the event that application is being made for a new domestic mechanical refrigerator to replace an old one, a sworn statement must be submitted from an authorized service organization explaining in full detail the condition of the equipment and why it cannot be repaired. It is the policy of W.P.B. not to release new refrigerators for replacement unless it is impossible to repair the old. It will also be necessary to certify that if a new refrigerator is made available the old one will be disposed of to a consumer or dealer immediately upon installation of the new.

Don't Be Annoyed if Orders Are Late, Manufacturers Beg

WASHINGTON, D. C.—Because of vital war work carrying ratings of AA, many manufacturers of sterilizers and other hospital equipment cannot give immediate delivery to hospitals when they obtain an A-1-j or an A-1-k rating, according to Everett Jones.

Orders without any priority rating when received by the manufacturers are usually put in the "unscheduled production list." When the rating is received, the order is transferred to the "scheduled production list." Then it must wait its turn as man hours become available to produce the item.

"Many hospitals are extremely disappointed," Mr. Jones states, "because they erroneously think that when the priority rating is granted, shipment can be made immediately. The rating, in most cases, merely permits the manufacturer to go ahead with the fabrication of the equipment when he can spare men from war work that carries much higher ratings."

Blood banks save minutes that save lives when emergency transfusions are necessary.

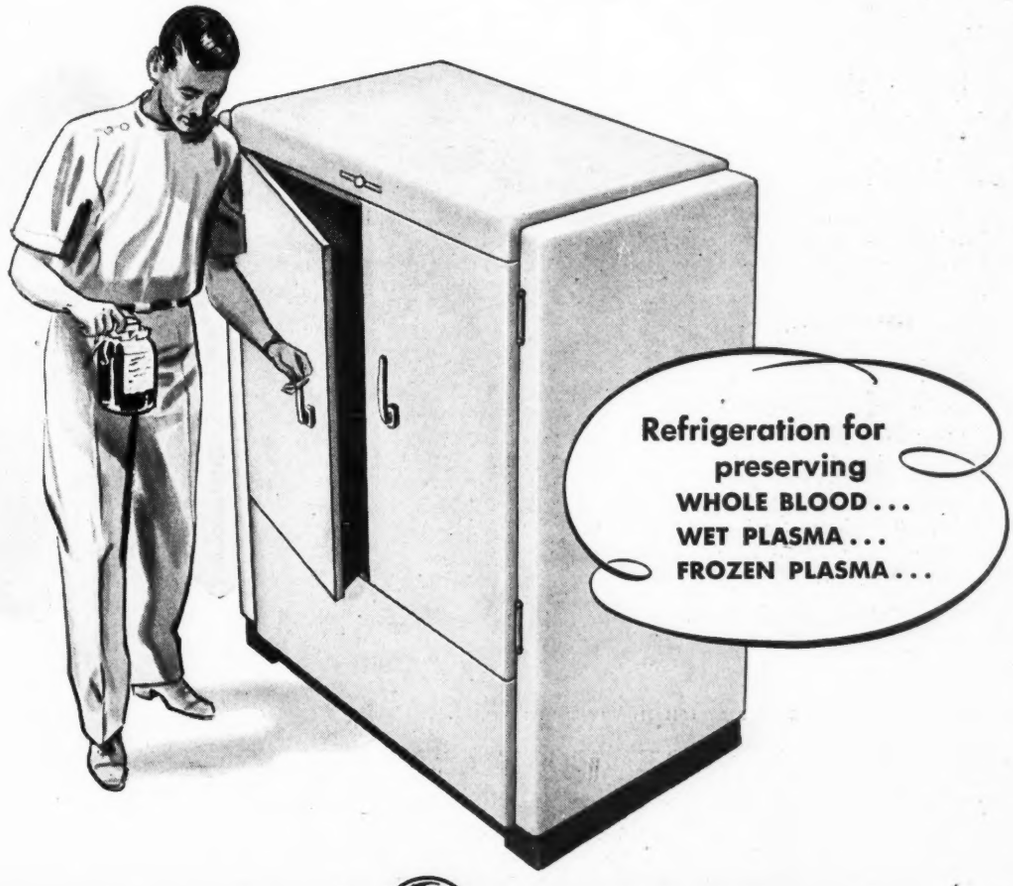
Whatever your Blood Bank problem

. . . TURN TO G-E

WHEN the first blood banks were established five years ago, General Electric engineers helped to pioneer this new use for refrigeration. Since that time, they have planned scores of blood bank installations in hospitals all over the country.

In planning a blood bank for your hospital, a number of technical problems will have to be faced. For expert help in getting the right answers, why not do what so many hospitals have done? — turn to G-E.

For further information, and the names of suppliers who produce blood bank cabinets using General Electric refrigeration, write to General Electric Company, Air Conditioning and Commercial Refrigeration Department, Division 3671, Bloomfield, New Jersey.



GENERAL ELECTRIC

Discrimination in Rationing Protested by Subcommittee

WASHINGTON, D. C.—The subcommittee on hospitals of the health and medical committee, W.P.B., has vigorously protested any discrimination between governmental hospitals and voluntary nonprofit hospitals with reference to all restrictions and rationing programs.

The committee pointed out that in meat rationing federal, state and municipal hospitals are allowed to obtain their full normal requirements, such deliveries being permitted without charge against the quotas of the distributors. The same arrangement should be made for voluntary hospitals, the committee demanded.

On December 15, Douglas C. Towson, director of Food Division, W.P.B., stated that action had been initiated to provide priority assistance to assure essential supplies to various agencies including hospitals. The order was in preparation and should be issued shortly, he stated.

Mileage Increased for Salesmen

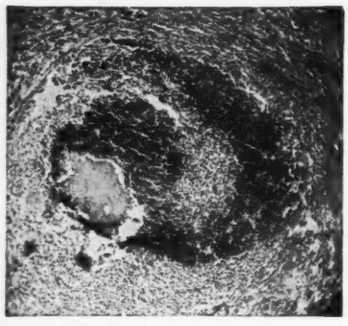
WASHINGTON, D. C.—Progress toward obtaining adequate gasoline and tires for sales and service men serving hospitals was made last month when it was announced December 8 that effective January 1 amendments to the mileage rationing regulations would permit "persons who require travel in pursuit of a principal and full-time activity devoted to the sale of essential . . . medical supplies" to apply for occupational mileage up to 8600 miles per year, or 65 per cent of last year's mileage, whichever is less. While this allowance is generally regarded as inadequate for many salesmen and service men, it establishes an important principle for the guidance of local rationing boards.

The MODERN HOSPITAL has joined with the Hospital Industries Association and the American Surgical Trade Association in making appeal for adequate gasoline and tires for such men.

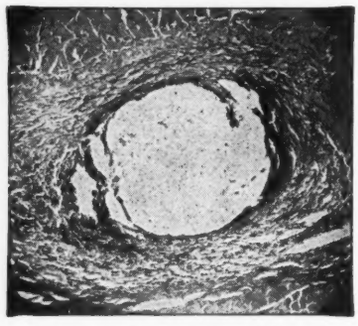
PLASTIGUT

A NEW UNIVERSAL SUTURE

—truly non-reactive, non-capillary, guaranteed physiologically inert



Plain catgut suture at two weeks; note absorption and inflammation



Plastigut suture at two weeks; no reaction, inflammation or absorption

An approach toward the ideal suture material is found in Plastigut Surgical Sutures, clinically developed by Dr. Joseph E. Bellas of Peoria. Plastigut is composed of synthetic plastic materials especially chosen with regard to suture requirements. Histological and clinical evidence proves it nonreactive, noncapillary and nonabsorbable. At any given stage, repair is more advanced in cases in which Plastigut is used than in those in which catgut is used. This is to be expected, since with Plastigut there is no irritating inflammatory and exudative reaction to hinder repair. There is no danger in leaving Plastigut in place; after two years it has been found intact, virtually a part of the supporting structures.

Plastigut is used in smaller sizes, due to its greater tensile strength. Plain Plastigut is offered in sizes No. 00, 4-0 and 5-0. Black, for skin work, is offered in sizes No. 0, 4-0 and 5-0. Size No. 00 is recommended for all general work, size No. 4-0 for ties, size No. 5-0 for plastic surgery and No. 0 for heavy tension sutures.

PRICE—Plastigut Sutures in Sterile Tubes, length 60 inches, all sizes. Dozen, $3.00. Gross, $29.50. Three-gross lots, per gross, $27.50.

References to the literature provided on request.

SHARP & SMITH HOSPITAL DIVISION

A. S. ALOE COMPANY

19th and Olive Sts. ST. LOUIS, MISSOURI

Aloe

H.R. 7311 Providing Hospital Benefits for Armed Forces Held Up

WASHINGTON, D. C.—H. R. 7311, proposing liberalization of benefits to members of the present armed forces, which passed the House has been held up by the Senate finance committee primarily because Brig. Gen. Frank T. Hines of the Veterans' Administration, although not actively opposing the bill, made no secret of the fact that he did not recommend it.

Since the major objective of the resolution, introduced by John Rankin of Mississippi, was to provide hospitalization for veterans of the present war, General Hines protested that it would enormously load up hospital facilities already dangerously strained. He stressed the anticipated need for hospital facilities for men still in the service and suffering battle injuries.

Red Cross Opens Recruiting of Nurses; 30,000 Sought

WASHINGTON, D. C.—Red Cross chapters throughout the nation will establish recruiting stations to sign up nurses for the armed forces, Mary Beard, director of the American Red Cross nursing service, announced December 10. It is an all-out effort to meet the Army's requirements of 30,000 nurses for 1943.

The Red Cross evaluates all applications regardless of whether the application is made directly to the Army or through the Red Cross. Almost 2100 nurses signed up in the Red Cross War Reserve during November, the largest total in history.

Gertrude Banfield, assistant director of Red Cross Nursing Service, announces that student nurses may now join the Red Cross Student Reserve at the beginning of their senior year instead of during the last six months.

How Armour Soaps Can Help You Make Linens Last Longer

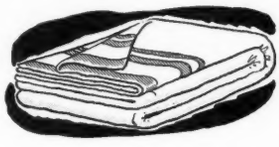
Armour Has Developed 8 Soaps to Launder Each Hospital Classification Correctly . . . Safely . . . Thoroughly

White Work

Flint Chips . . . The mechanical wear of extra rinses is avoided when you use Flint — a neutral, rich-sudsing, penetrating soap that rinses *freely*. A guaranteed titer between 41°-42°C. assures you that Flint will stand up under high temperatures needed to maintain whiteness. (Flint also comes in powdered form to use dry on wheel.)

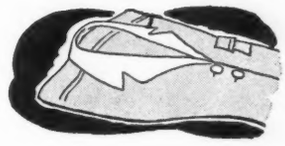
Giant Powder . . . To guard against discoloration and injury to fabric strength due to improper soap building, Giant — a high-titer, free-rinsing soap — is scientifically built with the correct amount of alkalies.

Blankets



Flotilla Flakes . . . The dangers of shrinkage and felting in washing woolens are minimized with Flotilla. This neutral soap contains no harmful alkalies . . . produces rich, easy-rinsing suds in cool water.

Colored Work



Hilo Powder . . . Protecting colors and fabrics while thoroughly removing soil is the job of Hilo. A scientifically blended soap, Hilo is also highly effective in the break on all classes of work.

Verdant Neutral Flakes . . . Silks, synthetics — the most delicate fabrics — and fugitive colors may be safely washed with Verdant, a gentle low-titer soap. (Verdant also comes in powdered form, or built in powdered form.)

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● Now — when your supplies and equipment must last — you will appreciate more than ever the quality, efficiency and safety of Armour Soaps. Armour chemically analyzes all raw materials, and scientifically controls each manufacturing step to assure highest quality and performance.

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Get in touch with Armour today. A representative will be pleased to show you how Armour's complete line of high quality soaps and cleansing agents can fill your wartime needs with the utmost satisfaction.

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Plasma Report of O.C.D. Reveals 128,130 Units Available for Treatment

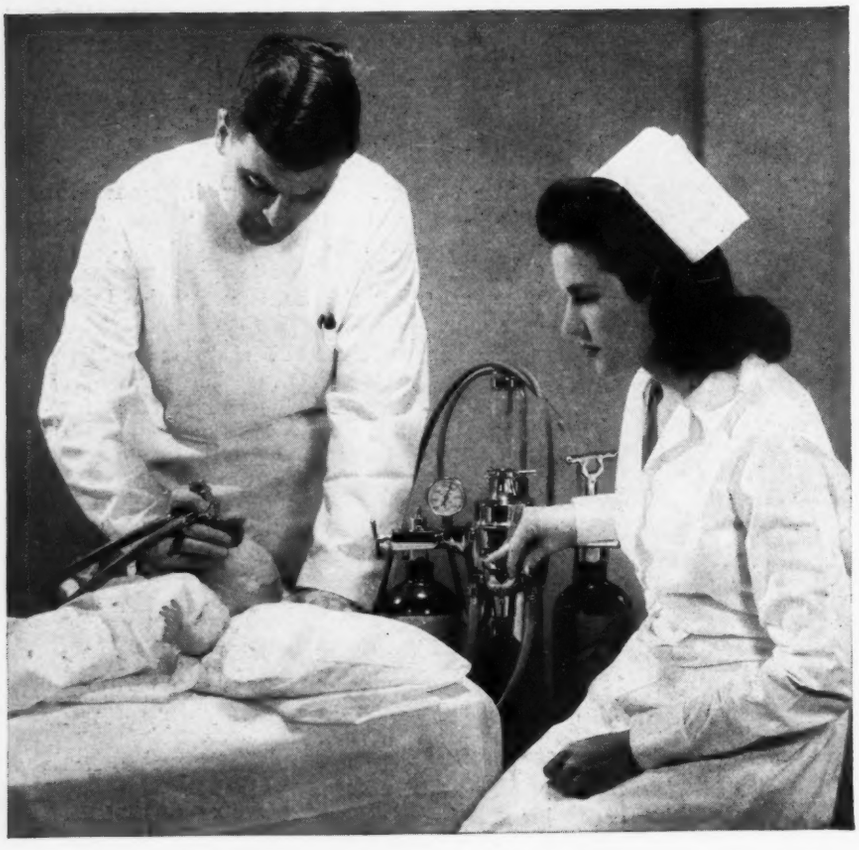
WASHINGTON, D. C.—A new method of administering morphine, a new civilian defense plan for mortuary service and a summary of the plasma program to date were O.C.D. events in December.

When the plasma report was compiled, there was a total reserve of 128,130 units in the continental United States for treatment of war casualties. This reserve is largely in the coastal target areas.

Grants-in-aid have been made to 130 hospitals that are preparing 63,130 units. In addition, 27,500 units of frozen plasma have been obtained from the Army and Navy from blood collected by the American Red Cross and distributed by O.C.D. In process of distribution are 37,500 units of dried plasma procured by O.C.D. from the Red Cross.

In addition to all this, the Red Cross is distributing to target areas 5000 units which will be available if needed for civilian casualties. Many hospitals that have not received grants are also preparing plasma reserves which total approximately 50,000 units.

The new method of administering morphine was developed because of the critical shortage of tin, resulting in a shortage of syrettes. A new glass and plastic device consists of a small sealed-glass ampule containing ¼ grain or ½ grain of morphine in solution.



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Special School to Train Nurses for Army Air Force

WASHINGTON, D. C.—Col. Julia O. Flikke, head of the Army nurse corps, on December 12 announced that, inasmuch as nurses serving with the air force must have certain specialized training, a special school will shortly be functioning for that purpose. The nursing personnel on duty with the Army air force will be placed under the direct control of the commanding general of the air force on the same basis as other medical department personnel.

The nursing service of the A.A.F. will be administered by a nursing division in the air surgeon's office. This division will be directed by Capt. Nellie V. Close and will have direct liaison with the nursing division of the surgeon general's office. It will function under the policies established by the superintendent of Army nurses.

Eastman Asks Canceling of All Nonessential Conventions

WASHINGTON, D. C.—All associations were urged to abandon meetings and conventions that will not contribute in an important way to winning the war in a statement issued on December 15 by Joseph B. Eastman, director of defense transportation.

Mr. Eastman asserted that individual associations must make their own decisions but that railroads and bus lines will have extremely limited facilities in 1943 for passengers not in the armed forces or not on business of an essential or emergency nature. Every convention or meeting canceled, he said, will constitute a contribution to the war effort.

"It will be agreed," Mr. Eastman stated, "that medical science is a subject of more than usual importance in war time. Yet the American Medical Association and several other medical groups have canceled their conventions."

Four Firms Get "E" Award

Four more organizations to which the Army-Navy "E" has been awarded for excellence in production have been announced recently. They are: American Optical Company, Southbridge, Mass., Convenience, Incorporated, Greenville, S. C.; Hobart Manufacturing Company, Troy, Ohio, and Owens-Corning Fiberglas Corporation, Toledo, Ohio.

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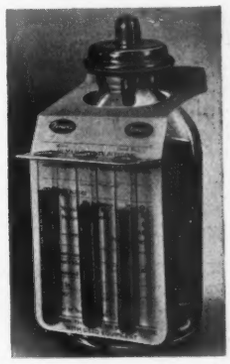

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O.C.D. Effects Economy of Organization and Manpower in Revised Instructions

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

As a result of Dr. George Baehr's recent visit to England a significant circular emanating from the Office of Civilian Defense, "Medical Series No. 23," was issued November 13. The urgency of conserving the fast-diminishing supply of civilian physicians and nurses, as well as wisdom gained from British experience in civil defense, forms the basis for certain economies in the organization and operation of field units.

Emergency medical field units are to be composed of *mobile medical teams* and no longer of squads or groups of teams. Each mobile medical team is to consist as heretofore of one physician, one nurse and two authorities. Only one express party will be dispatched to each major incident upon reception of the report of a bombing incident with casualties. An express party will consist of one rescue team, one mobile medical team, one ambulance and perhaps one passenger car or station wagon.

Ways to effect the movement and use of medical personnel are also outlined in the manual. Suggestions are given for reducing the number of casualty stations and for economy in their use. An important departure is the elimination of advanced first-aid posts. Only at a large incident with many casualties is the establishment of a first-aid post recommended and even then only with qualifications.

Stretcher teams are not required in the field. Whatever first aid is possible at incidents is given by the trained rescue workers under the direction of the incident doctor. As soon as the rescue teams have been organized and trained, stretcher teams will be either disbanded or transferred to the rescue service. An intensive training for rescue workers is shortly to be announced.

Another radical suggestion bears on ambulance units. To reduce the movement of vehicles during an air raid, to economize in driver personnel and to expedite the transport of large numbers of serious casualties from the incidents to hospitals, as many ambulances as possible should be remodeled so as to enable them to carry four stretchers. Adequate transportation of casualties in mass air raids in exposed cities in the target areas requires at least one four-stretcher ambulance for every 10,000 persons (depending on the location of hospitals and the distances to be covered), and half that number of passenger cars or station wagons for sitting cases. Specifications for the conversion of used cars into four-stretcher ambulances will be provided by the medical division of O.C.D.

Substitute Used Boilers for New Ones, W.P.B. Orders

WASHINGTON, D. C.—The critical shortage in plate and tubes for the manufacture of power boilers makes it essential that used boilers now available be substituted for new boilers whenever possible. Beginning immediately and until further notice, the power division of W.P.B. has been instructed not to schedule the production of boilers of 200 pounds' design pressure or less, or 500 rated h.p. or less, pursuant to Limitation Order L-117, as amended.

This order holds until the present supply of suitable used boilers has been carefully investigated or unless it can be demonstrated that a boiler for an essential war project must be especially built to meet some unusual condition.

Used boilers are available for moderate pressures in various parts of the country, many of them ready for immediate use. Others that are now installed can

Simplifies Nursing Care in Traction Cases

The HERZMARK-ADAMS TRACTION REEL

The Herzmark-Adams power spring traction apparatus can be used for all types of traction where pulleys and weights are now used. This includes skin or pin traction, skull traction, overhead traction from a frame, as well as counter traction. A removable key adjusts the traction to up to twenty pounds. A scale shows the number of pounds used. The apparatus is easily attached to any position on the bed, using only the attachments supplied.

FEATURES . . .

1. **No weights to handle. Traction up to 20 pounds set by the removable key. The apparatus is self-contained.**
2. **It provides constant traction since the weights are not bumped into and cannot become caught. Once the traction is adjusted and the key removed, visitors cannot change the adjustment.**
3. **Movement of the patient causes practically no variation in traction.**
4. **Easily attached with only the attachments supplied.**
5. **The apparatus is durably built . . . there is nothing to get out of order.**

NOTE: The elimination of swinging weights makes this apparatus ideal for use on board ship, train, plane or car.

No. B-1000 Herzmark-Adams Traction Reel with two 12″ horizontal bars and one 14″ vertical extension bar.....$34.50

Discounts for quantity. ***Prices higher outside U. S. A.***

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Alcohol purity is especially important in such applications as the dehydration of pathological specimens. In the automatic machine illustrated, specimens are immersed successively in nine jars, containing alcohol of progressively increasing strength, from 80% to 100%. Because U. S. I. Pure Alcohol helps keep specimens free from the danger of contamination that might affect accuracy of results, it is the choice of leading hospitals for this exacting application—and for every other purpose in laboratory, operating room, and pharmacy.

Check your requirements for alcohol with this convenient list of 21 major hospital applications ...and specify U. S. I. Pure Alcohol for every use.

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21 IMPORTANT HOSPITAL USES FOR ALCOHOL

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- ☐ Hypodermic Injections
- ☐ Massage and Sponge
- ☐ Pharmaceutical Preparations
- ☐ Pharmacy Solvent for Vegetable Drugs
- ☐ Preserving Specimens
- ☐ Protein Precipitant
- ☐ Spirit Lamps
- ☐ Stains and Reagents
- ☐ Sterilizing Instruments
- ☐ Sterilizing Skin
- ☐ Surgical Soap Preparation
- ☐ Sutures Sterile Solution
- ☐ Therapeutic Nerve Block

be dismantled and promptly shipped. The power division offers prompt assistance to any hospital in locating used boiler equipment.

Federal Funds Granted for Transporting Sick to Emergency Hospitals

WASHINGTON, D. C.—A directive recently issued to officials of Emergency Medical Service points out that federal financing of transportation necessary in evacuating casualties and other hospitalized sick to emergency base hospitals can be accomplished only through state evacuation authorities.

The directive urges regional medical officers, state chiefs of Emergency Medical Service and state hospital officers to cooperate with the state authority in order that provision can be made in advance for the financing of this phase of evacuation. Allotment of funds for all phases of evacuation will be made by the O.D.H.W.S. through its regional directors to state evacuation authorities and the several state agencies concerned in the fields of emergency medical service, health, welfare and education.

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Method of Obtaining Adequate Supplies of Meat Outlined

WASHINGTON, D. C.—A hospital that runs into difficulty with any one packer or supplier of meat must present complete facts covering the number of meals served per week and the amount of various kinds of meat needed to serve those meals to all packers and suppliers in its normal trade area, according to Maury Maverick, director, Governmental Division, W.P.B.

If after using all possible ingenuity to clear up the situation locally, a hospital still is unable to get the minimum necessary meat, then, and only then, should an appeal for help be made to John Madigan, W.P.B. administrator of the meat order.

No More Chicago Hotels to Army

The Edgewater Beach and other Chicago hotels are not to be taken over by the government as hospitals. In an exclusive interview with The MODERN HOSPITAL on December 19, William M. Dewey, president of the Edgewater Beach, stated that the reports that his hotel was to be taken over had become so persistent that they had sought and obtained an official statement from the War Department that no more Chicago hotels are to be taken over.

GENERAL NEWS

Caldwell's Resignation Accepted by A.H.A. at Meeting of Trustees

Dr. Bert W. Caldwell's resignation as executive secretary of the A.H.A., the highlight of the December meeting of the trustees, was announced by James A. Hamilton, president, in part as follows:

"At the annual budget meeting of the board of trustees of the American Hospital Association held today (December 12) in Chicago, Dr. Bert W. Caldwell submitted his resignation as executive secretary and as editor of *Hospitals*. Reaching the age of 68, he expressed his desire not to be considered for reappointment.

"With a deep feeling of appreciation to Doctor Caldwell for his many years of loyal and devoted service, the board of trustees accepted his resignation to take effect upon the appointment of his successors."

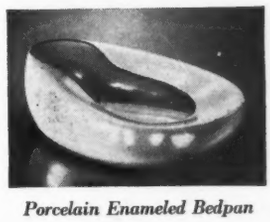
A commitee of eight has been appointed to canvass the field and present suitable names of persons as executive secretary and as editor to the trustees at the meeting in February. Another committee is also searching for candidates to serve as Washington representative of the

PUSS IN BOOTS, *ALIAS* LORD KITTEN

• *Puss in Boots was no* ordinary *cat. He stood out from the crowd because of his uncanny ability to forewarn the King of coming dangers. For this, the King gave him the title of "Lord Kitten."*

• Like Puss in Boots, Vollrath Enameled and Stainless Steel Ware stands out from the crowd. Knowing this, hospitals from coast to coast specify Vollrath kitchen and clinical ware. They know that their patients, and physicians too, recognize the quality and the craftsman-created character of Vollrath Porcelain Enameled and Stainless Steel Ware . . . Since 1874 —sixty-nine years ago—Vollrath has steadfastly maintained its well-deserved leadership . . . We urge you to investigate.

Vollrath NuSteel Liquid Cleaner



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Stainless Steel Irrigator

The Vollrath Co.

Genuine Vollrath Ware Bears This Label

VOLLRATH SINCE 1874

ESTABLISHED 1874

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A.H.A. This committee, also, is expected to report in February.

Other action taken by the trustees at the December meeting included adoption of the 1943 budget, ratification of President Hamilton's appointments to councils and special committees and ratification of the work of Doctor Bishop's committee on approval of Blue Cross plans. Several of the councils, the Hospital Service Plan Commission, the coordinating committee and many of the specific study committees of the association met during the week preceding the trustees' session.

New chairmen were appointed for all of the councils except the one on professional practice and the one on governmental relations. R. F. Cahalane of Boston heads the council on public education; George Bugbee is chairman of the council on hospital planning and plant operation; Ada Belle McCleery was named chairman of the council on association development, and Dr. Fraser D. Mooney is the new chairman of the council on administrative practice. They succeed Dr. R. H. Bishop, Dr. Lucius R. Wilson, Howard Bishop and Graham Davis, respectively. Dr. Robin C. Buerki and Dr. Claude W. Munger continue as council chairmen.

Other new council appointments include Everett Jones, Dr. N. W. Faxon, Miriam Curtis, Dr. Frank Bradley, F. Stanley Howe, Dr. W. S. Rankin, Arden Hardgrove, John Hatfield, Gerhard Hartman, Asa Bacon and William P. Butler.

An entirely new committee was authorized by the trustees, namely, a joint committee with the National Nursing Council for War Services. Doctor Buerki, Miss Curtis, Mr. Hamilton, Dr. Basil C. MacLean and Frank J. Walter were named to this committee.

The membership of the committee on approval of hospital service plans was revised and expanded. The members are Dr. Robert H. Bishop, Jessie Turnbull, Ray Amberg, Dr. Lewis W. Jarrett, Oliver Pratt, Dr. Anthony J. J. Rourke and Dr. G. Harvey Agnew. This committee, which formerly consisted of only three members all of whom were trustees, now contains only two trustees.

Newly appointed chairmen of other standing and board committees are: institute, Dr. Malcolm T. MacEachern; award of merit, Dr. Henry M. Pollock; by-laws, Dr. A. C. Bachmeyer; procedure of house of delegates, F. Stanley Howe; resolutions, Jessie J. Turnbull; representatives to the Advisory Committee on Medical Education, Doctor Buerki (with Dr. Wilmar M. Allen and Dr. A. J. Hockett); representatives to the Joint Advisory Committee of Nine, Mr. Hamilton, Monsignor M. F. Griffin and Doctor Munger.

Charles H. Dabbs was named to the nominating committee of assembly delegates and J. Stanley Turk, to the committee on nomination of officers, of which Dr. W. Franklin Wood is chairman.

Numerous changes were also made in the various study committees that function under the different councils.

California Hospitals Are Not Taxable, Superior Court Rules

A concerted attempt by the California Employment Commission to force all California voluntary hospitals into the taxpaying class was defeated on December 14 by the superior court for the county of Los Angeles which handed down a decision interpreting broadly the exemption contained in the California Unemployment Insurance Act. The commission attempted to require that 50 per cent of a hospital's work must be charity in order to permit exemption under the California act, which uses the same exemption clause as the federal Social Security Act and the federal Revenue Code.

In his decision Judge Emmet H. Wilson stated that it is not necessary that a charitable organization "go on the streets with coin boxes or tam-

★ At the outbreak of World War I, America was largely dependent on Europe for many of the tools of science—dyes, chemicals, and *laboratory glassware.*

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Less than 150 Items
T.M. REG. PYREX U.S. PAT. OFF.

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In the past quarter of a century, America's chemists and scientists have contributed to our chemical independence. And Corning Research in Glass has helped to make us independent in *laboratory glassware.*

Today, in Catalog LP21, are listed more than 2700 laboratory glassware items. They provide laboratory technicians with the equipment for more accurate, faster, and better work. The availability of a few specific items may be affected by the war effort, consult your laboratory supply dealer.

Here are the tools to help speed the laboratories of America and its Allies on their way to Victory. Corning Research will continue to serve in peace as in war, and to contribute to higher standards of performance.

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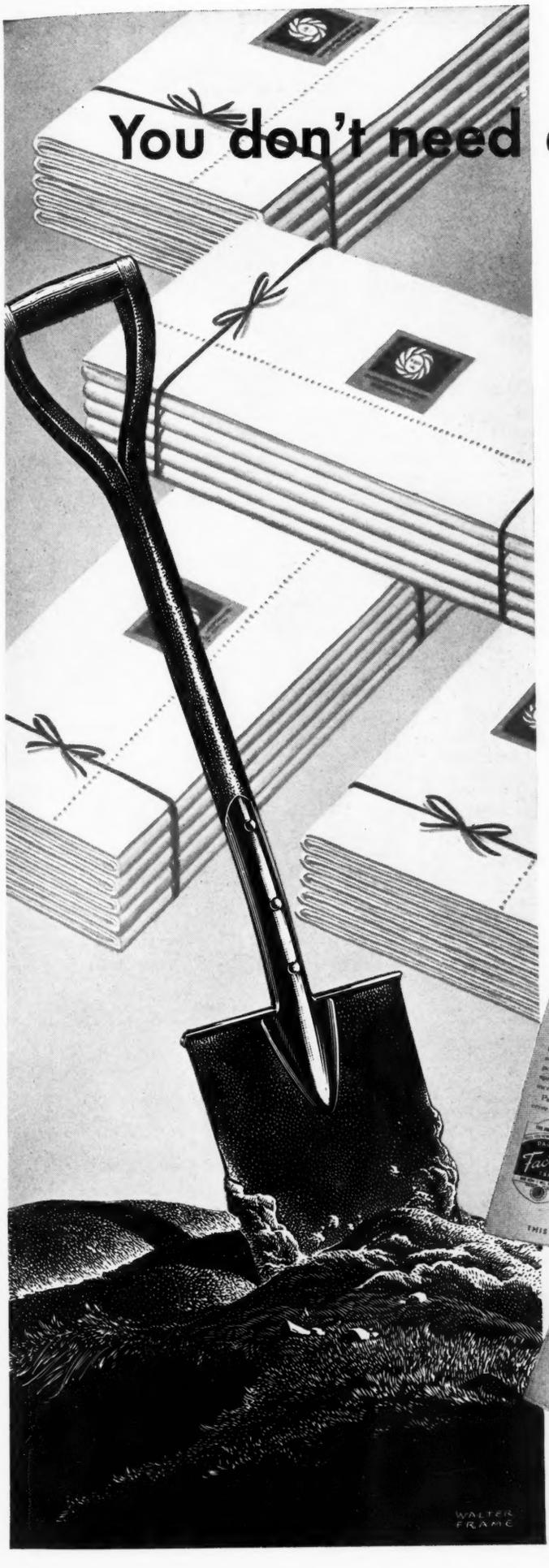

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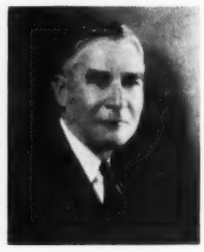
bourines. . . . It may collect from those who are able to pay . . . and use the remaining surplus in its charitable work. . . . Neither a certain defined amount of its expenditures for charity nor the percentage thereof in relation to its income . . . is the criterion. . . . The number of free beds maintained is only relative and is not important. There is no restrictive terminology in the statute from which it can be inferred that the legislature intended that a charity must be extensive in order to qualify under the tax. To tax a nonprofit hospital is to place a direct tax on the sick and injured."

Chile Honors U. S. Hospitals

The Medical Federation of Chile devoted the current (July-December) issue of *Medicina Social* in its entirety to an extensive résumé of hospital service in the United States. This issue is dedicated to the forty-fourth annual convention of the American Hospital Association held in St. Louis in October and 4000 copies have been distributed gratis. Thirty pages comprise a narrative, statistical and graphic presentation of hospital service in the United States. The cover page is illustrated with the American flag, a picture of the New York Hospital and an inscription to the A.H.A. convention.

15,000,000 Subscribers Is Blue Cross Goal; Louis H. Pink Succeeds Goldwater



A total of at least 15,000,000 Blue Cross subscribers by the end of 1943 is the new A.H.A.goal adopted in December.

All present Blue Cross plans were reapproved and the New Hampshire Hospitalization Service of Concord, N. H., was granted approval for the first time, bringing to 77 the total number of approved plans. Louis H. Pink, new president of the Associated Hospital Service of New York, was promptly elected to the Hospital Service Plan Commission to fill out the three year term of Dr. S. S. Goldwater and the standards for granting approval to Blue Cross plans were made more specific at various meetings held in Chicago last month.

Mr. Pink has been New York State superintendent of insurance since 1935. He has been connected with the state insurance department for ten years, although his background of experience is primarily in social, educational and charitable activities. He has been treasurer of the New York Child Labor Committee, chairman of the state housing board, a member of the New York City board of education, the New York City Housing Authority and the board of trustees of St. Lawrence University. He is a lawyer by training.

Mr. Pink will be assisted by the present officers of Associated Hospital Service.

The 15,000,000 enrollment goal was subdivided to give a specific goal for each approved plan. In general, a plan will not be approved, except in unusual circumstances, if it does not reach a minimum enrollment of 25,000 by the end of 1943. The specific enrollment goals for each plan were submitted to it for comment before final adoption by the committee on approval.

A committee of the Hospital Service Plan Commission is considering the formation of a national mutual cash benefit medical and surgical corporation. Such a corporation would provide uniform contracts available to all Blue Cross plans.

The War Labor Board aided Blue Cross plans by announcing last month that employers' payments for medical

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in the watches of the night

Night duty brings its problems to the busy floor nurse who finds too many tasks for her hands and not enough time to do them in.

Like the rest of the hospital staff, she takes the plumbing equipment for granted. The valves must work quickly at a touch of knee or hand—the waste must drain rapidly—the smooth gleaming surface of fixtures must stay smooth and gleaming despite the tougher than average service to be expected in a hospital where there is no time to "baby" equipment.

And in hospitals the country over, night nurses *can* take the equipment for granted where hospital architects and supervisors, plumbing contractors and head surgeons have seen to it that Crane sanitary equipment is provided.

For the name Crane on hospital equipment has come to stand for high quality plus high efficiency and more and more hospitals are seeing to it that Crane equipment is installed when a hospital is newly built or modernized.

The New Jersey Medical Center at Jersey City, completed in 1942, comprises 17 separate buildings and is one of the most modern hospital centers in the United States. The plumbing is Crane throughout.

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and hospital service protection need not be included in computing a wage or salary. The War Department is also cooperating as regards its civilian employes. The American Farm Bureau, on December 7, reaffirmed its approval of Blue Cross plans.

The Hospital Service Plan Commission decided to give more intensive study to the enrollment of individuals, to the development of low-cost plans (possibly with a deductible or partial coverage), and to existing medical service plans, and it endorsed the Coffee Bill (or its successor) for federal support of medical service for public assistance groups.

The approval commitee of the trustees announced that the standards for approval would be enforced more rigorously in 1944.

McDiarmid Urges Doctors to Cooperate With Hospitals

The influence of the doctor in persuading the patient to accept the inconvenience and annoyances that are part of the war emergency was emphasized by Col. N. L. McDiarmid, superintendent, Columbia Hospital for Women, Washington, D. C., speaking recently before the Medical Society of the District of Columbia. At the same time he urged cooperation of the medical staff with the hospital administration. Rooms may not be as thoroughly cleaned and refurnished as formerly. However, if patients can be discharged early in the day and no later than 3 p.m., rooms can be better prepared.

"Don't send patients to the hospital until you have ascertained that accommodations will be available," the speaker advised, "and don't send them in before the hour when the room is to be available.

"Arrange for admission of operative cases before 5 p.m. of the day prior to the operation. Compliance with this hospital rule will be of great help.

"Avoid suggestions to patients that they should be transferred because of minor differences of accommodations. Such transfers are expensive to the hospital and time-consuming on the part of nurses.

"Failure to cancel reservations when decision has been made that they will not be used is obviously a detriment to the hospital and to other individuals needing hospitalization.

"Don't fail to advise patients that accommodations of the particular type desired may not be immediately available and under no circumstances advise them that you have arranged for charges at the rate desired regardless of the accommodations utilized unless you have made such arrangements with the business office.

"Be cooperative about visiting hours and encourage patients to comply with the rules.

"Remember reimbursement must be obtained for actual expenditures. Don't assure patients that some indefinite credit arrangements desired by them will be satisfactory. Advise them to make arrangements with the hospital prior to admission."

Minnesota Institute Program Announced; Starts January 11

The last institute to be held in the Center for Continuation Study, University of Minnesota, for the duration will occur on January 11 to 16. Subsequent war-time institutes at this university will have to be held in other quarters as Waves are to be housed in the center.

The institute, which will be sponsored by the university with the A.C.H.A. and the Minnesota Hospital Association cooperating, will emphasize the problems of hospital administration incident to the war. The tentative program adopted last month stresses (1) problems involving the various hospitals' services and personnel, (2) plant maintenance and supplies and (3) postwar planning, including

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In Williams Lanolin Soap uncombined alkali is virtually non-existent. It contains no fatty acids, no dye, no strong perfume. We use the finest oils on the market, use them liberally, and in a way that precludes rancidity.

In our honest opinion, no soap is more gentle to a dry or irritated skin . . . to the sensitive skins of infants.

Patients like the delicate fragrance and quick lather of Williams Lanolin Soap. For economy, each cake is subjected to extremely high pressure; it is a very lasting soap.

Let us send you a full-size cake of Williams Lanolin Soap. Then you can judge its merits firsthand. Just mail us your name and address—your home address, if you wish. There's no obligation, of course. Offer good in U.S.A. only.

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Gentlemen: I'll be glad to accept your offer of a full-size cake of Williams Lanolin Soap.

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definition of services, financial arrangements, future of volunteers.

All hospital administrators and assistant administrators are eligible to attend the institute. Full information and registration forms can be obtained from Dr. William A. O'Brien, University of Minnesota.

High Prices, Low Food Stocks Facing Hospital Buyers

Increasing prices and growing shortages faced the food buyer for hospitals during December, according to information supplied to The MODERN HOSPITAL. In the New York market, for example, the average cost per pound of 25 major beef, lamb, veal, pork and poultry items was approximately 35 per cent over the March price and 58 per cent over the December 1940 average.

A shortage of wood pulp and transportation in 1943 will send up the prices of paper products and cut the supply.

Government reservation of 50 to 55 per cent of the pack of canned fruits and fruit juices, vegetables and vegetable juices will require a 10 to 15 per cent reduction in civilian consumption next year.

Hospitals in New York have been advised to institute an immediate 30 per cent cut in butter consumption.

Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

U. S. Army

Welby E. Abrams (Capt.), Carle Memorial Hospital, Urbana, Ill.

L. C. Austin (Capt.), Menorah Hospital, Kansas City, Mo.

Lawrence E. Kresge, Auburn City Hospital, Auburn, N. Y.

Grace Mjelde, R.N., Shawano Municipal Hospital, Shawano, Wis.

George E. Peale, California Hospital, Los Angeles.

E. Bryan Quarles, Barnes Hospital, St. Louis.

U.S.O. Hospitality in California Now Extended to Army, Navy Nurses

Army and Navy nurses stationed in San Francisco have their own U.S.O. lounge in the St. Francis Hotel to which they may go for rest and relaxation, companionship or information about the city.

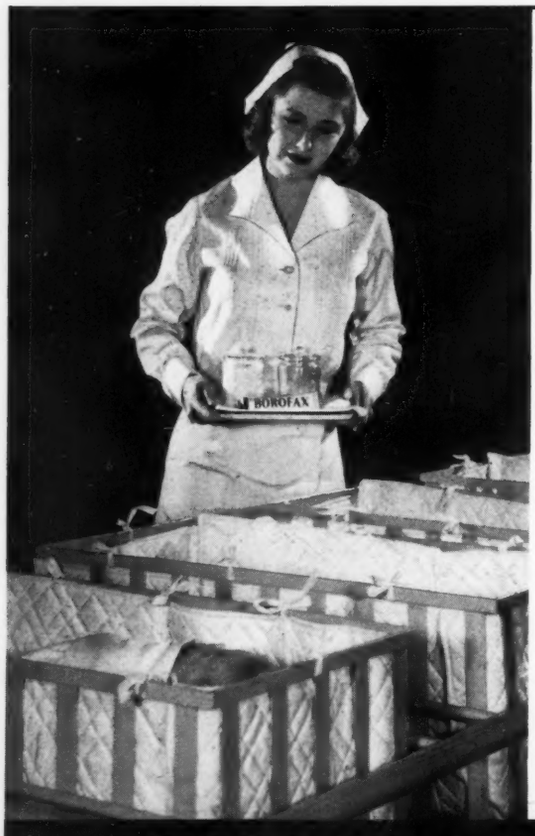
The lounge was established at the instigation of Mrs. Harold R. McKinnon, chairman of the U.S.O. Women's Committee of Northern California, who recognized the need for such a center for service nurses, especially those from out of the state who have few friends or acquaintances in California.

Various women's clubs in the city have offered the services of their organizations to the lounge and the nurses are free to use the swimming pools, libraries, dining rooms and gymnasiums of these clubs whenever they have the time from their duties.

The idea has spread to other sections of California. In Monterey, luncheons at the Pebble Beach Racket Club and picnics at La Playa Ranch in Carmel Valley are given for nurses and once a week, swimming lessons are given to a nurses' class at the Del Monte pool.

Nurses' Aides to Be Paid

In an effort to solve the nursing shortage problem, Ottawa Civic Hospital, Ottawa, Ont., recently devised the plan of offering an intensive seventy-two hour course in hospital training for women volunteers and offering them regular employment at the rate of $1.70 per day and one meal. They can work either four or eight hours. The decision to pay these V.A.D.'s, or nurses' aides, was reached because, it is claimed, the purely volunteer method has failed in many cities owing to the number of demands on women's time.



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NOTE: 'Borofax' is widely used as a dressing for fissured and cracked nipples of the nursing mother.

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American Atrabine Approved

American-made atrabine, a substitute for quinine in the treatment of malaria, is as good as that made in any other country, according to the *Journal* of the A.M.A. for November 14. "When the Netherlands East Indies fell to Japan, the source of practically the entire world supply of quinine was lost to the United States," the *Journal* states. "Atrabine, now officially recognized under the nonproprietary name of quinacrine, assumes a rôle of unsurpassed importance as a strategic drug."

Alberta Elects New President

Elected president of the Alberta Hospital Asociation, J. M. Findlay succeeds Dr. A. H. Baker, now superintendent of the tuberculosis division of the Provincial Department of Health and head of Keith Sanatorium, Calgary. Mr. Findlay was formerly secretary of the Red Deer Municipal Hospital, Red Deer, Alta.

Hospital Renamed for Goldwater

New York City's Mayor La Guardia recently announced that the Welfare Hospital for Chronic Diseases will now be known as the Goldwater Memorial Hospital.

Pittsburgh Plan Revises Contract

Revisions in the contract of the Hospital Service Association of Pittsburgh were being made last month to cut down on some of the more expensive services and to increase other services. The cuts would reduce x-ray benefits to those examinations necessary in accident cases only; would limit obstetric care to ten days, regardless of complications, except cesarian sections which would be treated as surgical cases, and would require a small service fee of patients who are on a direct payment basis. The revised contract will, however, extend service to long-stay patients by paying for one third of the normal allowances for the twenty-second to the ninetieth day, provided the stay is continuous.

N. H. D. Committee Subdivided

The National Hospital Day committee has been divided into two sections: a large advisory committee on public education and National Hospital Day to represent the various state and sections associations and a small awards committee consisting of R. F. Cahalane, Dr. R. H. Bishop and Father John Bingham. It was also decided by the council on public education at its December meeting that hereafter N.H.D. awards will be made for a continuing year-round public education program ending on National Hospital Day. Provision has been made for other possible classes of awards, such as for hospital house organs, a newspaper campaign or radio program.

Army Needs Physical Therapy Aids

Recent Army communications have stressed the shortage of trained physical therapy technicians. Announcement has been made through the U. S. Civil Service Commission that applications for this work will be accepted from women only. Because of the need for nurses in the Army and Navy nurse corps, student aides must be drawn largely from women who have the requisites of a college degree in physical education or a minimum of two years of college work that includes biology and other sciences.

Wilinsky Honored on Birthday

The sixtieth birthday anniversary of Dr. Charles F. Wilinsky was recently celebrated by his friends at a reception given at the Beth Israel Hospital in Boston. In honor of the occasion he received a bound book of letters of felicitation from his many friends and associates.

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PURE CONCENTRATED

ORANGE AND GRAPEFRUIT JUICES

...a war-time conservation measure, too!

Overburdened transportation facilities have already resulted in shortages of consumer supplies . . . higher prices. Aside from a lowered cost per serving, one case of Sunfilled No. 5 hermetically sealed containers is the equivalent in juice potential and shipping or storage space of 13 crates of fresh oranges. An adequate supply of Sunfilled may well be regarded as a far-sighted means of insuring wholesome, nutritive citrus fruit juices for the duration.

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Latin Americans Awarded Dazian Research Fellowships

Fellowships for research at Mount Sinai Hospital, New York City, have been awarded two Latin American physicians, Dr. Enrique Washington Lithgow of the Dominican Republic and Dr. Oscar Martinez Gomez of Mexico. The fellowships, covering a year of research at the New York hospital, are supported by the Dazian Foundation for Medical Research for the purpose of strengthening good will between the United States and Latin American countries.

The Bethune medical scholarships, established in 1941 in memory of Dr. Norman Bethune, a Canadian physician who was one of the organizers of medical service for China's northwest guerrilla region, are being offered again this year, the China Aid Council announces. The scholarships are to be awarded yearly to two students who distinguish themselves in the medical field.

Goldwater Will Probated

Mount Sinai Hospital, New York City, will benefit to the extent of $2500 under the terms of the will of Dr. S. S. Goldwater, filed in the Surrogate's Court the end of October. The will revealed that Doctor Goldwater left an estate of "more than $10,000."

Michigan C.I.O. Out for Group Medical Service Plan

The Michigan state C.I.O. council recently approved a health program proposed for its entire membership which includes the following statement: "Press for the expansion and stabilization of nonprofit group hospitalization and medical service plans (this involves a statewide assault on the reactionary minorities in the medical societies, whose disruptive and anti-social conduct has seriously interfered with the functioning of these plans in Michigan)."

The plan also urged expansion of the workmen's compensation coverage, government aid for the erection of union-owned and union-operated hospitals and medical centers and government sponsored health security for all low income groups.

Catgut Labels Called Inadequate

The council on pharmacy and chemistry of the A.M.A. announces in a recent issue of the *Journal of the American Medical Association* that the present labeling of surgical catgut on the market is inadequate. The investigators report that the terms, "twenty day" and "forty day" catgut, are unreliable insofar as tensile strength in the tissue is concerned.

New Edition of Nursing Facts

"Facts About Nursing, 1942," a convenient source of information for those who have occasion to deal with the broader aspects of nursing, especially in its relation to the war effort, has recently been released by the nursing information bureau of the American Nurses' Association. Successor to the 1935, 1938, 1939 and 1941 editions, the booklet stresses the supply and distribution of the nation's nursing power. Original sources are indicated for those who are interested in obtaining supplementary information.

Michael Reese "Baby" Christened

Michael Reese Hospital's latest "baby," a new monthly paper by and for employes of this Chicago institution, made its debut recently. Christened the *Mirror*, the paper aims at friendly relations in the organization. Its name won a $5 award for Louise Pruitt, a messenger.

Hospital Campaign on Last Lap

The United Hospital Campaign to keep 76 voluntary nonprofit hospital members of the United Hospital Fund going at full efficiency has collected $1,042,941.08 to date. The organization now enters the final quarter of its drive to raise $1,383,729.61.

Garden Fresh Peas...12 minutes from Package to Plate!

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. . . their vitamins and minerals are captured and held for the moment they come to your kitchens!

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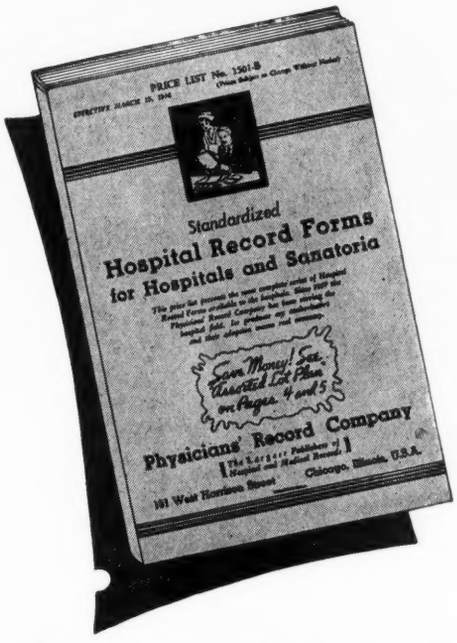
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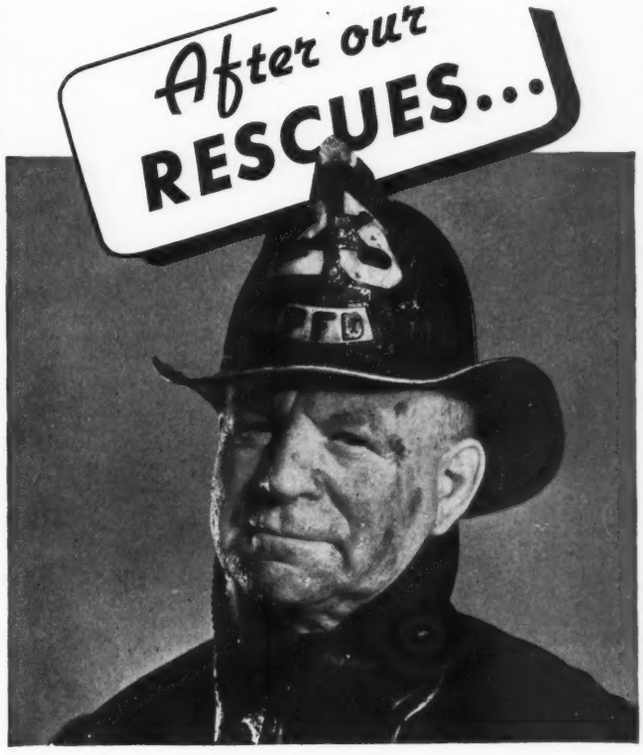

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Serious burns call for prompt, effective treatment in the "emergency room." The Gomco Aspirating Pump (shown below) can be had with special spray hose and provides the ideal equipment for rapidly spraying tannic acid and similar solutions.

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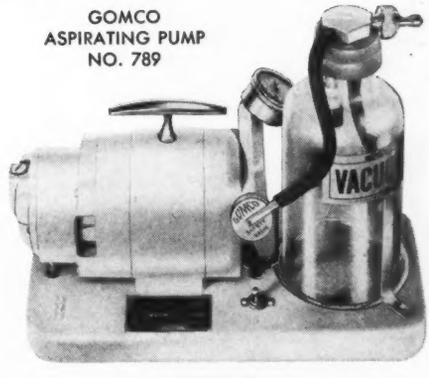

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ASPIRATING PUMPS

Simplify Insulating Practices

Revised simplified practices on structural insulating board (vegetable fiber) are now available from the division of simplified practice, National Bureau of Standards. The current revision adds to the schedule of recommended standards one size of building board, 4 by 6 feet in ½, ¾ and 1 inch thicknesses. It also eliminates the ½ inch thick 3 by 8 foot sheathing. Copies can be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C.

NAMES IN THE NEWS

Administrators

Dr. Emanuel Giddings, former medical superintendent at Kings County Hospital, Brooklyn, N. Y., and at present colonel in the Army Medical Corps stationed at the Walter Reed Hospital in Washington, has been appointed colonel of the 37th General Hospital, Brooklyn, N. Y.

Grace Mjelde, superintendent of the Shawano Municipal Hospital in Shawano, Wis., has obtained a leave of absence from her duties and has joined the Army Nurse Corps.

Dr. R. F. Waddell, formerly superintendent of the Mission Clinic, Bangkok, Thailand, has been appointed medical director of the Boulder-Colorado Sanitarium and Hospital, Boulder, Colo.

L. F. Bohner, recently of Singapore and previously of the New England Sanitarium, Melrose, Mass., is the new business manager of the institution.

Gladys A. Cooper, formerly of the American Oncologic Hospital in Philadelphia, is the new superintendent at the Home for Consumptives, Chestnut Hill, Philadelphia.

Merton E. Knisely has been appointed administrator of St. Luke's Hospital, Milwaukee.

Vergil F. Bradfield of the medical school at Wayne University, Detroit, has accepted the assistant superintendency of the University Hospital, Baltimore.

Emily C. Allison has left the Mary Washington Hospital, Fredericksburg, Va., to become the superintendent of the Annie M. Warner Hospital, Gettysburg, Pa.

Rose Q. Strait, formerly at the Glens Falls Hospital, Glens Falls, N. Y., is now administrator at the Saratoga Hospital, Saratoga Springs, N. Y.

Nelle A. Kelley has been appointed administrator at Defiance Hospital, Defiance, Ohio.

Lenore Roby has left the Hale-Willard Memorial Hospital, Anna, Ill., to take up new duties at the Las Vegas Hospital, Las Vegas, N. M.

David W. Park, M.D., is the new administrator for the Potsdam Hospital, Potsdam, N. Y.

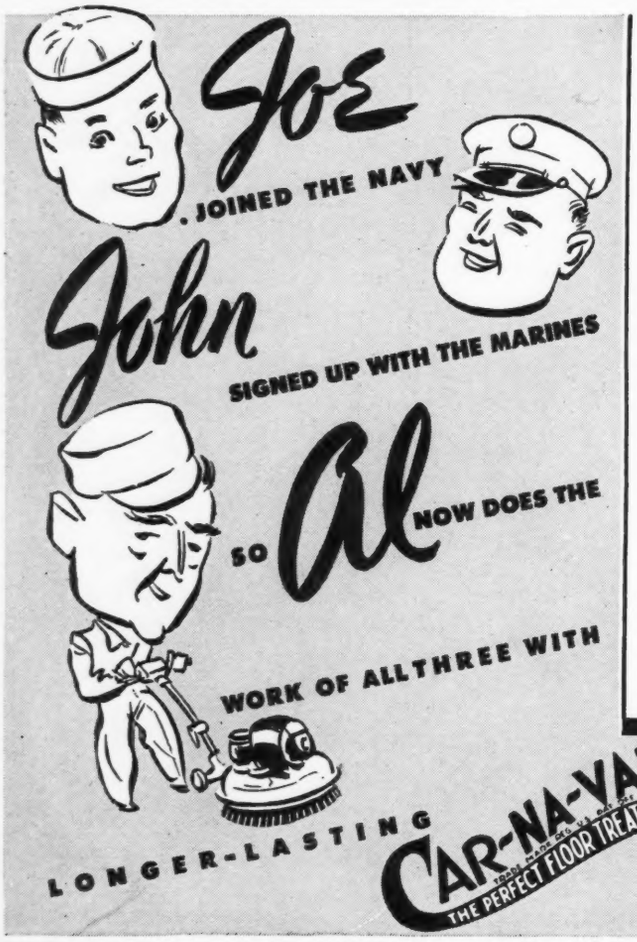
Henry Wallace has accepted the administrative responsibilities of the Washoe County General Hospital, Reno, Nev.

Mark L. Ball, formerly business manager of the Massachusetts Osteopathic Hospital, Boston, has been appointed superintendent of the Hospital Cottages for Children, Baldwinsville.

Mary Larter, who was superintendent of North Adams Hospital, North Adams, Mass., for eighteen years, has recently assumed her duties as head of Mary Washington Hospital, Fredericksburg, Va. She succeeds **Emily C. Allison,** now head of Annie M. Warner Hospital, Gettysburg, Pa.

L. C. Austin, administrator of Menorah Hospital, Kansas City, Mo., has been commissioned as captain in the Medical Administrative Corps of the Army.

Dr. Magnus C. Petersen, former medical superintendent of the Willmar State Hospital, Willmar, Minn., has accepted a similar position at the Rochester State Hospital, Rochester, N. Y., succeeding **Dr. B. F. Smith. Dr. George**



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Again in 1943, Hygeia advertising says,

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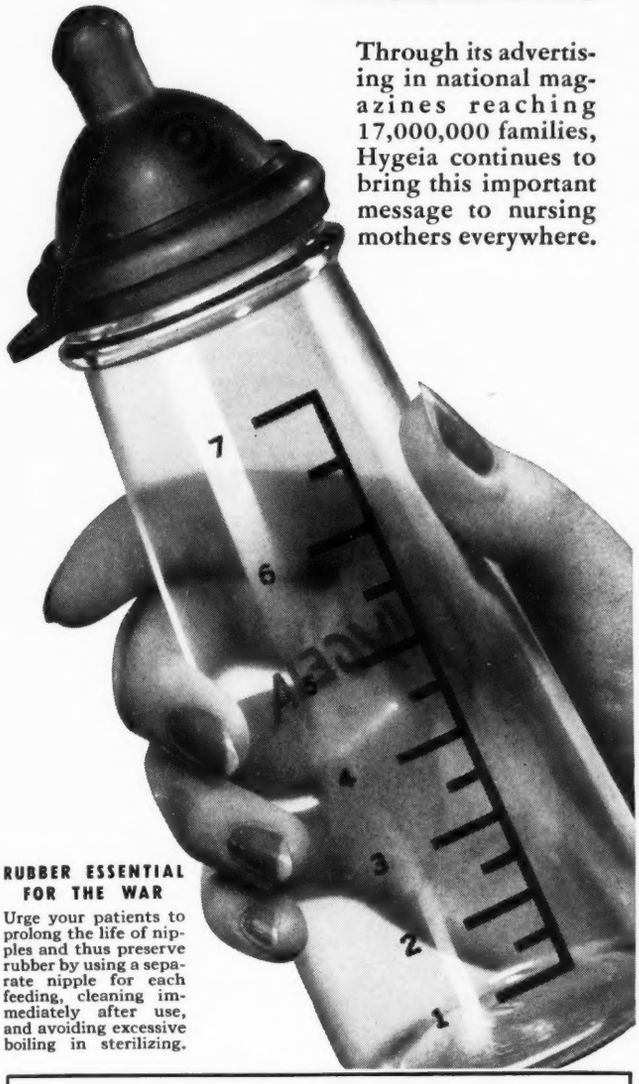

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A. D. 1943. A world at war. Number of men and women available for staffs of civilian hospitals—limited. Importance of keeping civilians active in war production work—life and death.

There's a way to keep every hospital in the country at peak efficiency—actually DOING the work of two hospitals in normal times. That way is to make sure that every member of the complex hospital organization is keen about his own role—eager to give it everything he has—and a little bit more.

If you are less than avid for each new day of action, perhaps you are not in THE spot for you. We suggest that you send for one of our analysis sheets, indicating the general phase of hospital service in which you are now engaged. We may find that what you need is more responsibility—or less. Perhaps you are taking orders when you should be giving them—or vice versa.

In helping you to find yourself—we'll be a step further toward our goal of helping all hospitals to 100% efficiency in 1943. Your correspondence with us will be treated as confidential. Our service is nationwide.

M. BURNEICE LARSON

Director, THE MEDICAL BUREAU

PALMOLIVE BUILDING CHICAGO

H. Freeman, medical superintendent of St. Peter State Hospital, St. Peter, Minn., is acting superintendent at the Willmar institution pending the appointment of a successor to Doctor Petersen.

Dr. Francis E. Carrington has been appointed director of the Minneapolis General Hospital during the absence of **Dr. Donald W. Pollard,** who is in active service.

Alan Leamy, head of the welfare department of Jackson County, Michigan, has been made manager of W. A. Foote Memorial Hospital, Jackson, Mich. **H. H. Kelsey** was made comptroller of the institution at the same time.

Dr. Robert L. Dixon has been appointed acting superintendent of the Lapeer State Home and Training School, Lapeer, Mich., succeeding the late **Dr. Fred R. Hanna.**

Dr. W. E. Clark recently announced his retirement as assistant superintendent and clinical director of Mississippi State Hospital, Whitfield, Miss.

Dr. E. Bryan Quarles, assistant superintendent of Barnes Hospital, St. Louis, has received a leave of absence to enter the Army air forces. **Dr. Mary Caroline Abney** has joined the hospital staff as administrative assistant to the superintendent.

Newman M. Biller, assistant director of Montefiore Hospital, New York City, has been appointed executive director of the Home for Aged and Infirm Hebrews, New York City. He will be succeeded at Montefiore Hospital by **Dr. Sigmund L. Friedman.**

Lawrence E. Kresge has been given a leave of absence from his position as superintendent of the Auburn City Hospital, Auburn, N. Y., to accept a commission in the Army Medical Administrative Corps. **Jerome F. Peck Jr.** has been named acting superintendent for the duration.

George E. Peale, formerly assistant superintendent and auditor at California Hospital, Los Angeles, has been commissioned second lieutenant in the Army Medical Administrative Corps. **Kenneth R. Drent** will assume the duties of auditor for the hospital. **Frank G. Swain,** now at Santa Monica Hospital, is personnel director for the two institutions with offices at California Hospital.

Ralph W. Lee, former finance manager of Middlesex Hospital, Middletown, Conn., has resigned. **Bernard C. Dyer** has been employed in his place. Mr. Dyer was formerly with the Sinai Hospital, Baltimore.

Welby E. Abrams, administrator of the Carle Memorial Hospital, Urbana, Ill., has accepted a commission as captain in the Army Medical Administrative Corps.

Department Heads

Rachel B. Mayhew, formerly assistant dietitian at Roosevelt Hospital, New York City, has been made chief dietitian at Nassau Hospital, Mineola, N. Y., succeeding **Mildred Kleyla,** who has resigned.

Julia T. Vesley, formerly of Lenox Hill Hospital, New York City, has been appointed director of nurses at Easton Hospital, Easton, Pa. She succeeds **Louise E. Schroeder,** who resigned to become general secretary for District 4, Ohio State Nurses' Association.

Dr. Frank C. Sutton has been appointed assistant medical director of Rochester General Hospital, Rochester, N. Y.

Bertha Gross, former housekeeper at the Gary Hotel, Gary, Ind., has been named executive housekeeper for the Chicago Intensive Treatment Center, Chicago.

Miscellaneous

Dr. Jean Alonzo Curran, formerly dean of the Long Island College of Medicine, Brooklyn, N. Y., has been installed as president.

Peter Klein, who has been the director of the North Dakota Hospital Service Association, is the new head of the Associated Hospital Service of Massachusetts.

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HOSPITAL administrators faced with critical shortages in necessary equipment can come to us and be confident that we will have the hospital furniture they need—in beautiful, enduring wood that gives years of perfect service. This bedside cabinet is an example—a large supply is available for immediate shipment in your choice of walnut, rock maple, honey maple, or Early American maple finish. Write for prices and descriptive literature.

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For Better Furniture

DESIGNERS and BUILDERS of SUPERIOR QUALITY HOSPITAL FURNITURE
3501 Butler Street . . . PITTSBURGH, PA.
ESTABLISHED 1873

IN INDUSTRIAL FIRST AID

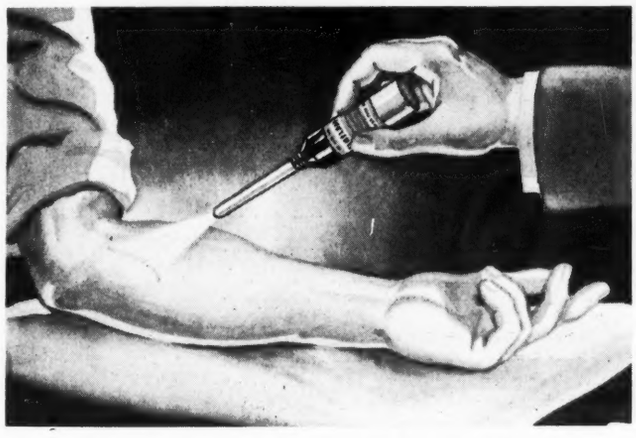
SULFANILAMIDE

(FLINT)

In prophylaxis as well as in therapy, Sulfanilamide (Flint) has been found effective on topical application.

The medication is present in sufficiently high concentrations to combat various organisms. It obviates the undesirable effects of oral administration.

In a series of industrial wounds, a mild degree of local anesthesia has been observed following applications to denuded surfaces. There is no apparent interference with normal healing mechanism. No local irritating effect on tissue cells.



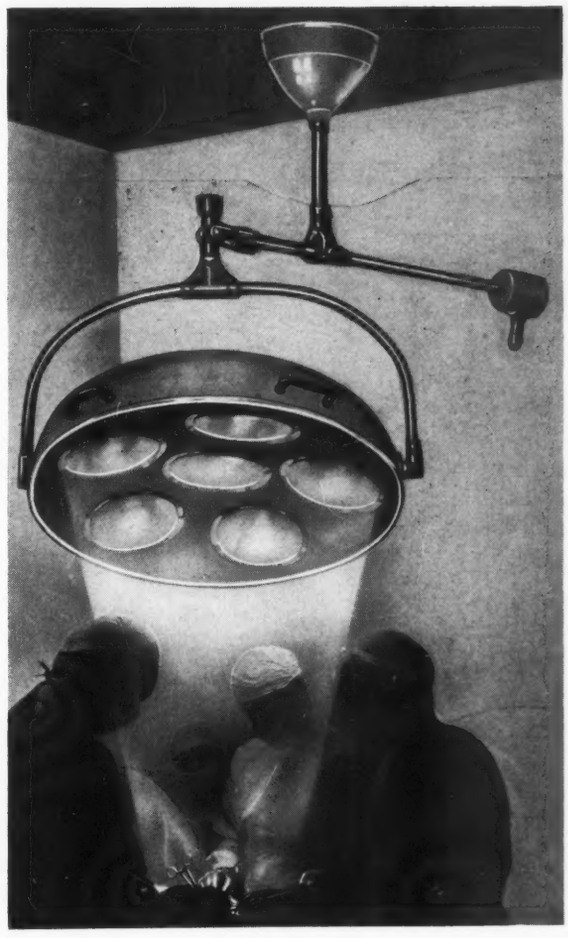
Use Sulfanilamide (Flint) in wounds, compound fractures, localized purulent lesions, burns, lacerations and otolaryngology.

Supplied in ½ oz. insufflator tubes. Nozzle attachment at slight additional cost.

Send for data on clinical uses of Sulfanilamide (Flint).

FLINT, EATON & COMPANY
DECATUR · ILLINOIS

Here's a Light that Surgeons really like!



More Light Inside the Incision!

• That's the reason for the enthusiastic acceptance of PROMETHEUS Operating Lights . . . more light *inside the incision!* Built as a result of contact with hundreds of surgeons, this light delivers *cool shadowless, color-corrected* light illuminating the cavities properly.

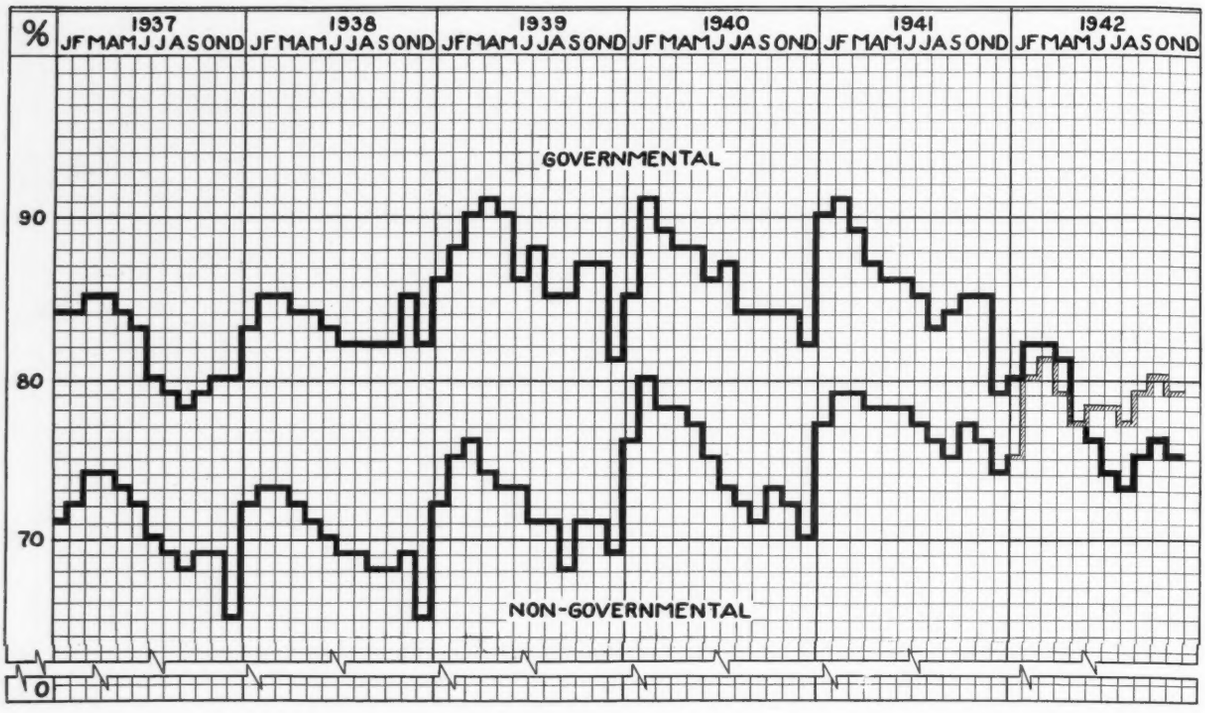
Illustrated: Model No. 158. A counter balanced operating light, adjustable in height, to any angle, at any point around the operating field. Individual light sources, each 13" in diameter, cool-beam heat filters, and color correction lens.

Write for Literature

• **LESS HEAT** • **LESS SHADOW**

PROMETHEUS ELECTRIC CORP.
MANUFACTURERS OF QUALITY SURGICAL EQUIPMENT SINCE 1901
401 WEST 13th STREET • NEW YORK, N. Y.

Construction in 1942 Nearly $7,000,000 Over 1941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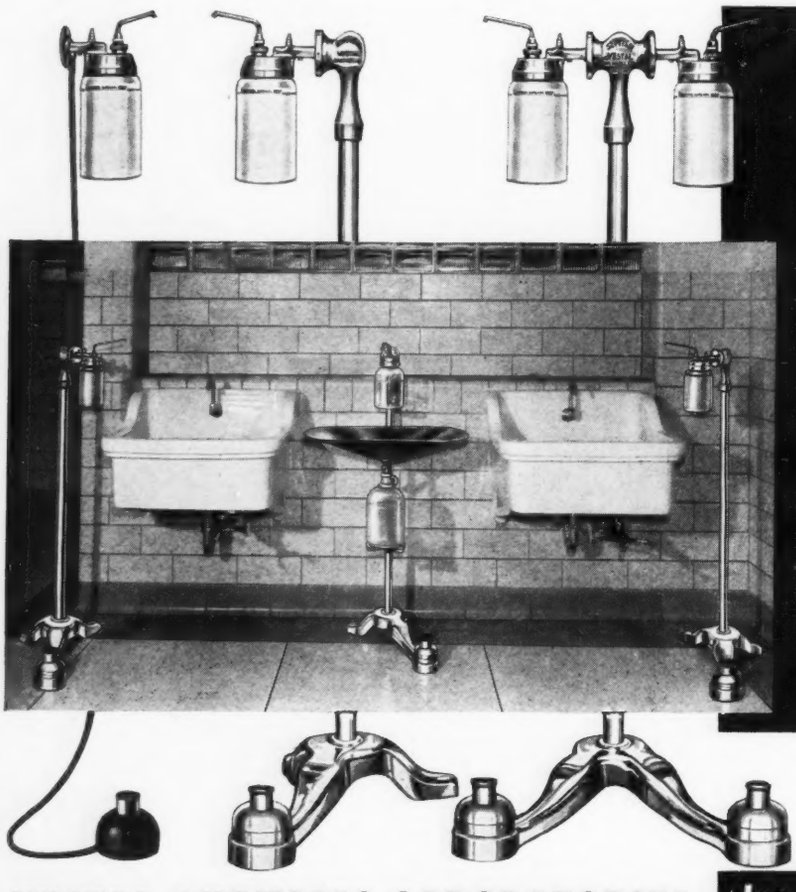
GOVERNMENTAL
NON-GOVERNMENTAL
90
80
70
0

Occupancy in nongovernmental general hospitals continued at a high level during November, still substantially above that in governmental general hospitals.

A total of 22 new hospital construction projects was reported in the period from November 16 to December 14, of which 20 gave cost figures totaling $18,443,000 In this period 32 projects were discontinued involving $7,973,000. The net value of construction announced since January 1 is $160,460,000 as compared with $153,480,000 for the same period of last year.



PERFECTION in PERFORMANCE and ECONOMY . . .

The New Improved SEPTISOL DISPENSERS put real efficiency into scrub-up room technique. Give the surgeon as much—or as little—soap where and when he wants it. Prevent costly soap waste . . . protect your investment in soap.

So Easy to Use. A feather touch of the foot instantly releases the soap. The control valve, exclusive with Septisol Dispensers, regulates the flow—from a few drops to a full ounce. Prevents wasteful dripping. No moving parts—nothing to wear out. 3 models—double portable, single portable and wall type. All attractively finished.

SEPTISOL SURGICAL SOAP...

is scientifically prepared from olive oil, cocoanut oil and other fine vegetable oils. Made especially for use in scrub-up rooms. It lathers to a smooth creamy richness helping to eliminate dangers of infection and roughness that come from use of harsh, irritating soaps.

VESTAL CHEMICAL LABORATORIES, Inc. ST. LOUIS · NEW YORK

AFTER HOURS

More War Surpluses?

SHORTLY AFTER the close of World War I, vast quantities of hospital stores in warehouses in this country and in France, including stocks of surplus equipment and expendable supplies, were thrown on the domestic market. Speculators bought them in at government auctions at a fraction of their value and were able to offer them for sale at prices far below actual production cost.

Hospitals enjoyed a momentary price advantage on a wide range of items and seemed, on the surface, to benefit. Actually, the hospital dollar did go further for a little while. But for every such sale to hospitals, manufacturers lost volume and profit. Many of them faced a desperate financial problem and not a few were forced to the verge of bankruptcy. Had not these surplus stores been exhausted when they were, many manufacturers would have gone out of business, taking from available sources of supply a large number of firms whose long-range service to the hospital field has been incalculable.

Now, once again tremendous stores of medical and hospital equipment and supplies are being accumulated by the federal government. They are being warehoused at home and shipped to the four corners of the earth for use by our own forces and our allies. No one can foresee the war's end, but on the day after victory these stores will, in turn, become "surplus." Obviously, the production of these supplies must go on to the end, but it is not too early for hospitals, suppliers and governmental agencies to begin thinking about what is to become of them when the war is over.

The most obvious method of disposal is suggested by the fact that the United States has already become the arsenal and the storehouse for the democratic nations. Upon us will devolve the gigantic task of rehabilitating all belligerents after the peace is signed. For some time we will be forced to feed the world. It seems logical that from both a practical and a humanitarian point of view we should contribute all usable surplus to the vast medical care and hospitalization program that will be necessary. This possibility is discussed in an editorial on another page of this issue.

American industry is now making tremendous sacrifices to the war effort with profits held to a minimum by contract and taxation. It is manifestly unfair that the government, having demanded this sacrifice, should repay it by dumping the goods so produced at distress prices in competition with the manufacturer who made them at a restricted profit and who, at best, will find conditions none too favorable in the post-war economy. It is scarcely conceivable that manufacturers could stand behind such distress merchandise and provide the guaranties and service that hospitals have learned to expect. Unless the manufacturer can sell at a reasonable profit, he cannot stay in business. Failure of these producers would contribute to postwar unemployment, reduce corporate and personal income from which taxes may be drawn and eliminate healthy competition which always benefits the consumer. Many suppliers fall into the category of small business, without huge financial reserves. Deprived of rightful income, their contributions of research and development will lag behind medical technic and health needs. The permanent welfare of hospitals depends in a large measure upon trustworthy sources of supply. To destroy these cannot fail to work ultimate hardship upon the entire field.

The MODERN HOSPITAL, in cooperation with hospital and supply leaders, is now endeavoring to project a program that will encompass the best interests of the entire hospital field. Progress will be reported in subsequent issues of the magazine.

—THE PUBLISHER

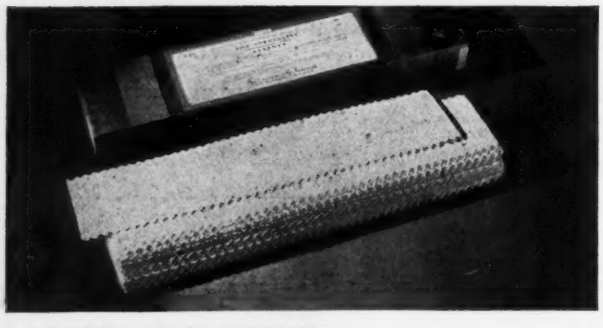
"SPECIALIST"

Hard-Coated Bandage

HOLDS ITS PLASTER

• A specially-processed plaster-of-Paris paste, spread on the crinoline and then baked to a hard-coated mass, gives the "Specialist" bandage a dustless, uniform coating that stays on—yet saturates instantly and sets in 5 to 8 minutes. Elimination of loss of loose, falling plaster and uniform coating from end to end enable you to make stronger, lighter casts with fewer bandages when you use "Specialist."

SEND FOR FREE TRIAL SUPPLY



"SPECIALIST" SPLINTS Handy cut lengths of "Specialist" bandage. Molded to arm or leg, they fit perfectly, and provide complete immobilization.

HOSPITAL DIVISION Johnson & Johnson

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